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September – October 2007



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## ACCESS TO CARE

**Geraghty EM et al Primary care visit length, quality, and satisfaction for standardized patients with depression. *Journal of General Internal Medicine* 6/10/2007 DOI: 10.1007/s11606-007-0371-5**

Background: The contribution of physician and organizational factors to visit length, quality, and satisfaction remains uncertain, in part, because of confounding by patient presentation. Objective: To determine associations among visit length, quality, and satisfaction when patient presentation is controlled. Design: A factorial experiment using standardized patients to make primary care visits presenting with either major depression or adjustment disorder, and a musculoskeletal complaint. Participants: One hundred fifty-two primary care physicians, each seeing 2 standardized patients. Measurements: Visit length was determined from surreptitiously obtained audiorecordings. Other key measures were derived from physician and standardized patient report. Results: Mean visit length for 294 completed encounters was 22.3 minutes (range = 5.8-72.2, SD = 9.4). Key factors associated with visit length were: physician style ( $\rho = 0.68$  and  $0.54$  after multivariate adjustment), nonprofessional experience with depression (11% longer, 95% CI = 0-23%), practicing within an HMO (26% shorter, 95% CI = 61-90%), and greater practice volume (those working >9 half-day clinic sessions/week had 15% shorter visits than those working fewer than 6, 95% CI = 0-27%, and those seeing >12 patients/half-day had 27% shorter visits than those seeing <10 patients/half-day, 95% CI = 13-39%). Suicidal inquiry (a process-based quality-of-care measure for depression) was not associated with adjusted visit length. Satisfaction was linearly associated with visit length but not with suicide inquiry or follow-up interval. Conclusions: Despite experimental control for clinical presentation, wide variation in visit length persists, largely reflecting individual physician styles. Visit length is a significant determinant of standardized patient satisfaction.

**Gravelle H, Siciliani L Is waiting-time prioritization welfare improving? *Health Economics* In press Epub 18/7/2007 DOI: 10.1002/hec.1262**

Rationing by waiting time is commonly used in health care systems with zero or low money prices. Some systems prioritise particular types of patient and offer them lower waiting times. We investigate whether prioritisation is welfare improving when the benefit from treatment is the sum of two components, one of which is not observed by providers. We show that positive prioritisation (shorter waits for patients with higher observable benefit) is welfare improving if the mean observable benefit of the patients

who are indifferent about receiving the treatment is smaller than the mean observable benefit of the patients who receive the treatment. This is true (a) if the distribution of the unobservable benefit is uniform for any distribution of the observable benefit; or (b) if the distribution of the observable benefit is uniform and the distribution of the unobservable benefit is log-concave. We also show that prioritisation is never welfare increasing if and only if the distribution of unobservable benefit is negative exponential.

**Hirvonen J et al** Is longer waiting time associated with health and social services utilization before treatment? A randomized study *Journal of Health Services Research and Policy* October 2007 12 (4) 209-21 DOI: 10.1258/135581907782101606

Objective: To determine whether longer waiting time for major joint replacement is associated with health and social services utilization before treatment. Methods: When placed on the waiting list, patients were randomized to short (=3 months) or a non-fixed waiting time. Utilization measures were the use of home health care, rehabilitation and social services before treatment. Results: A total of 833 patients with osteoarthritis of the hip or knee joint were recruited into the study. Six hundred and twenty-two patients were included in the analysis. The majority of patients were not using any services before hospital admission for joint replacement surgery. The most commonly used service was unpaid home help provided by relatives, neighbours, friends and volunteers (informal care). In both groups, private support services were utilized more often than public ones. Patients with a short waiting time were more likely than those with a non-fixed waiting time to use rehabilitation (13.5% versus 8.2%,  $P = 0.032$ ) and visiting care services (7.5% versus 3.9%,  $P = 0.054$ ). Conclusions: Only a few patients used professional care. They were more likely to require informal care during the waiting time. A longer waiting time did not result in a higher utilization rate before admission for treatment.

## CHRONIC ILLNESS

**Aragones, E** Assessment of an enhanced program for depression management in primary care: a cluster randomized controlled trial. The INDI project (Interventions for Depression Improvement). *BMC Public Health* 7:253 DOI: 10.1186/1471-2458-7-253

Background Most depressed patients are attended at primary care. However, there are significant shortcomings in the diagnosis, management and outcomes of these patients. The aim of this study is to determine whether the implementation of a structured programme for managing depression will provide better health outcomes than usual management. Methods Design: A cluster-randomized controlled trial involving two groups, one of which is the control group consisting of patients who are treated for depression in the usual way and the other is the intervention group consisting of patients on a structured programme for treating depression. Setting: 20 primary care centres in the province of Tarragona (Spain) Sample: 400 patients over 18 years of age who have experienced an episode of major depression (DSM-IV) and who need to initiate

antidepressant treatment Intervention: A multi-component programme with clinical, educational and organisational procedures that includes training for the health care provider and evidence-based clinical guidelines. It also includes primary care nurses working as care-managers who provide educational and emotional support for the patients and who are responsible for active and systematic clinical monitoring. The programme aims to improve the primary care/specialized level interface. Measurements: The patients will be monitored by telephone interviews. The interviewer will not know which group the patient belongs to (blind trial). These interviews will be given at 0, 3, 6 and 12 months. Main variables: Severity of the depressive symptoms, response rate and remission rate. Analysis: Outcomes will be analyzed on an intent-to-treat basis and the unit of analysis will be the individual patient. This analysis will take into account the effect of study design on potential lack of independence between observations within the same cluster. Discussion The effectiveness of caring for depression in primary care can be improved by various strategies. The most effective models involve organisational changes and a greater role of nurses. However, these models are almost exclusively from the USA, and this randomized clinical trial will determine if this approach could be effective to improve the outcomes of depression in primary care in the Spanish health care system.

**Bont J et al Is co-morbidity taken into account in the antibiotic management of elderly patients with acute bronchitis and COPD exacerbations? *Family Practice* August 2007 24 (4) 317-322 DOI: 10.1093/fampra/cmm023**

Background. Guidelines on acute lower respiratory tract infections recommend restrictive use of antibiotics, however, in patients with relevant co-morbid conditions treatment with antibiotics should be considered. Presently, it is unknown whether GPs adhere to these guidelines and target antibiotic treatment more often at patients with risk-elevating conditions. Objectives We assessed whether in elderly primary care patients with acute bronchitis or exacerbations of chronic pulmonary disease (COPD), antibiotics are more often prescribed to patients with risk-elevating co-morbid conditions. Methods. Using the Utrecht GP research database, we analysed 2643 episodes in patients of 65 years of age or older with a GP-diagnosed acute bronchitis or exacerbation of COPD. Multivariable logistic regression analysis was applied to determine independent determinants of antibiotic use. Results. Antibiotic prescribing rates were high in both acute bronchitis (84%) and in exacerbations of COPD (53%). In acute bronchitis, only age was an independent determinant of antibiotic use [odds ratio (OR) 1.03, 95% confidence interval (CI) 1.003–1.048], whereas in exacerbations of COPD antibiotics were more often prescribed to male patients (OR 1.3, 95% CI 1.0–1.5), patients with diabetes (OR 1.7, 95% CI 1.1–2.4) and heart failure (OR 1.3, 95% CI 1.0–1.7). Conclusion. Dutch GPs prescribe antibiotics in the majority of elderly patients with acute bronchitis and in half of the episodes of exacerbations of COPD. Tailoring their antibiotic treatment according to the presence or absence of high-risk co-morbid conditions could help GPs in improving antibiotic use in patients with respiratory tract infections in primary care.

**George GT, et al. Brief Intervention in Type 1 diabetes - Education for Self-efficacy (BITES): Protocol for a randomised controlled trial to assess biophysical and psychological effectiveness. *BMC Endocrine Disorders* 2007;7:6 14/9/2007 DOI: 10.1186/1472-6823-7-6**

**Background** Self management is the cornerstone of effective preventive care in diabetes. Educational interventions that provide self-management skills for people with diabetes have been shown to reduce blood glucose concentrations. This in turn has the potential to reduce rates of complications. However, evidence to support type, quantity, setting and mode of delivery of self-management education is sparse. **Objectives:** To study the biophysical and psychological effectiveness of a brief psycho-educational intervention for type 1 diabetes in adults. **Methods Design:** Randomised controlled clinical trial. **Setting:** Multidisciplinary specialist diabetes centre. **Hypothesis:** Our hypothesis was that the brief (2.5-day) intervention would be biophysically and psychologically effective for people with type 1 diabetes. **Intervention:** A brief psycho-educational intervention for type 1 diabetes developed by a multi-professional team comprising of a consultant diabetologist, a diabetes specialist nurse, a specialist diabetes dietician and a clinical health psychologist and delivered in 20 hours over 2.5 days. **Primary outcomes:** HbA1c and severe hypoglycaemia. **Secondary outcomes:** Blood pressure, weight, height, lipid profile and composite psychometric scales. **Participants:** We shall consent and recruit 120 subjects with postal invitations sent to eligible participants. Volunteers are to be seen at randomisation clinics where independent researcher verify eligibility and obtain consent. We shall randomise 72 to BITES and 72 to standard care. **Eligibility Criteria:** Type 1 diabetes for longer than 12 months, multiple injection therapy for at least two months, minimum age of 18 and ability to read and write. **Randomisation:** An independent evaluator to block randomise (block-size = 6), to intervention or control groups using sealed envelopes in strict ascendant order. Control group will receive standard care. **Assessment:** Participants in both groups would attend unblinded assessments at baseline, 3, 6 and 12 months, in addition to their usual care. After the intervention, usual care would be provided. **Ethics approval:** York Research Ethics Committee (Ref: 01/08/016) approved the study protocol. **Discussion** We hope the trial will demonstrate feasibility of a pragmatic randomised trial of BITES and help quantify therapeutic effect. A follow up multi-centre trial powered to detect this effect could provide further evidence. **Trial registration:** Current Controlled Trials ISRCTN75807800

**Hamilton W, Kernick D. Clinical features of primary brain tumours: a case-control study using electronic primary care records. *British Journal of General Practice* . 2007 57 (542) :695-9.**

**Background:** Around 4500 new primary brain tumours are diagnosed in the UK each year. Symptoms of these tumours have not previously been studied in primary care. **Aim:** To identify and quantify the clinical features of brain tumours in primary care. **Design of**

study: Case-control study. Setting: The General Practice Research Database, UK. Method: A total of 3505 patients with primary brain tumours diagnosed between May 1988 and March 2006, and 17 173 controls, matched for age (to 1 year), sex, and general practice, were studied. Full medical records for 6 months before diagnosis were searched for reports of clinical features previously associated with brain tumours. Odds ratios were calculated for variables independently associated with cancer, using conditional logistic regression, as were the positive predictive values for patients consulting in primary care. Results: Seven features were associated with brain tumours before diagnosis. Positive predictive values against a background risk of 0.013% were: new-onset seizure, 1.2% (95% confidence interval [CI] = 1.0 to 1.4); weakness (as a symptom), 3.0% (95% CI = 1.7 to 4.9); headache, 0.09% (95% CI = 0.08 to 0.10); confusion, 0.20% (95% CI = 0.16 to 0.24); memory loss, 0.036% (95% CI = 0.026 to 0.052); visual disorder, 0.035% (95% CI = 0.025 to 0.051); and the physical sign of motor loss on examination, 0.026% (95% CI = 0.024 to 0.030); all  $P < 0.001$ , except for visual disorder,  $P = 0.005$ . In a sub-analysis by age, the maximum risk of a brain tumour with headache or new-onset seizures was found in the age group 60-69 years (0.13% and 2.3% respectively). Conclusion: The findings suggest that isolated headache presented to primary care has too small a risk of an underlying brain tumour to warrant investigation at presentation. However, new-onset seizures should be investigated

**Laatikainen, T Prevention of Type 2 Diabetes by lifestyle intervention in an Australian primary health care setting: Greater Green Triangle (GGT) Diabetes Prevention Project *BMC Public Health* 19 September 2007 7:249 DOI: 10.1186/1471-2458-7-249**

Background Randomised controlled trials demonstrate a 60 percent reduction in type 2 diabetes incidence through lifestyle modification programmes. The aim of this study is to determine whether such programmes are feasible in primary health care. Methods An intervention study including 237 individuals 40-75 years of age with moderate or high risk of developing type 2 diabetes. A structured group programme with six 90 minute sessions delivered during an eight month period by trained nurses in Australian primary health care in 2004-2006. Main outcome measures taken at baseline, three, and 12 months included weight, height, waist circumference, fasting plasma glucose and lipids, plasma glucose two hours after oral glucose challenge, blood pressure, measures of psychological distress and general health outcomes. To test differences between baseline and follow-up, paired t-tests and Wilcoxon rank sum tests were performed. Results At twelve months participants' mean weight reduced by 2.52 kg (95 percent confidence interval 1.85 to 3.19) and waist circumference by 4.17 cm (3.48 to 4.87). Mean fasting glucose reduced by 0.14 mmol/l (0.07 to 0.20), plasma glucose two hours after oral glucose challenge by 0.58 mmol/l (0.36 to 0.79), total cholesterol by 0.29 mmol/l (0.18 to 0.40), low density lipoprotein cholesterol by 0.25 mmol/l (0.16 to 0.34), triglycerides by 0.15 mmol/l (0.05 to 0.24) and diastolic blood pressure by 2.14 mmHg (0.94 to 3.33). Significant improvements were also found in most psychological measures. Conclusions This study provides evidence that a type 2 diabetes prevention programme using lifestyle intervention is feasible in primary health care settings, with reductions in risk factors approaching those observed in clinical trials. Trial Number: Current Controlled Trials ISRCTN38031372

**Parsons S et al, Prevalence and comparative troublesomeness by age of musculoskeletal pain in different body locations *Family Practice* 2007 24 (4) 308-316 DOI: 10.1093/fampra/cmm027**

Background. Chronic pain has large health care costs and a major impact on the health of those affected. Few studies have also considered the severity of pain in different parts of the body across all age groups. Objectives. To measure the prevalence and troublesomeness of musculoskeletal pain in different body locations and age groups, in a consistent manner, without using location specific health outcome measures. Methods. A cross-sectional postal survey of 4049 adults registered with 16 MRC General Practice Research Framework practices. Frequency of chronic pain overall and troublesome pain by location and age was calculated. Logistic regression was undertaken to explore the relationship between chronic pain and demographic factors. Results. We received 2504 replies; response rate 60%. The prevalence of chronic pain was 41%. The prevalence of chronic pain rose from 23% in 18-24 year olds reaching a peak of 50% in 55-64 year olds. Troublesome pain over the last 4 weeks was commonest in the lower back (25%), neck (18%), knee (17%) and shoulder (17%). Troublesome wrist, elbow, shoulder, neck and lower back pain were most prevalent in the 45- to 64-year-age groups. Troublesome hip/thigh, knee and ankle/foot pain were most prevalent in those aged 75 or more. Conclusions. Great efforts have been made to develop and test treatments for low back pain. Our findings suggest that the overall prevalence of troublesome neck, knee and shoulder pain approaches that of troublesome low back pain and that similar efforts may be required to improve the management these pains.

**Paul G ,et al Development of a complex intervention to test the effectiveness of peer support in type 2 diabetes. *BMC Health Services Research* 2007 7:136 DOI: 10.1186/1472-6963-7-136**

Background: Diabetes is a chronic illness which requires the individual to assume responsibility for their own care with the aim of maintaining glucose and blood pressure levels as close to normal as possible. Traditionally self management training for diabetes has been delivered in a didactic setting. In recent times alternatives to the traditional delivery of diabetes care have been investigated, for example, the concept of peer support which emphasises patient rather than professional domination. The aim of this paper is to describe the development of a complex intervention of peer support in type 2 diabetes for a randomised control trial in a primary care setting. Methods: The Medical Research Council (MRC) framework for the development and evaluation of complex interventions for randomised control trials (RCT) was used as a theoretical guide to designing the intervention. The first three phases (Preclinical Phase, Phase 1, Phase 2) of this framework were examined in depth. The Preclinical Phase included a review of the literature relating to type 2 diabetes and peer support. In Phase 1 the theoretical background and qualitative data from 4 focus groups were combined to define the main components of the intervention. The preliminary intervention was conducted in Phase 2. This was a pilot study conducted in two general practices and amongst 24 patients and 4 peer supporters. Focus groups and semi structured interviews were conducted to collect additional qualitative data to inform the development of the intervention. Results: The

four components of the intervention were identified from the Preclinical Phase and Phase 1. They are: 1. Peer supporters; 2. Peer supporter training; 3. Retention and support for peer supporters; 4. Peer support meetings. The preliminary intervention was implemented in the Phase 2. Findings from this phase allowed further modeling of the intervention, to produce the definitive intervention. Conclusions: The MRC framework was instrumental in the development of a robust intervention of peer support of type 2 diabetes in primary care. Trial registration: Current Controlled Trials ISRCTN42541690

**Paul GM, et al Peer support in type 2 diabetes: a randomised controlled trial in primary care with parallel economic and qualitative analyses: pilot study and protocol. *BMC Family Practice* 2007 8:45 DOI: 10.1186/1471-2296-8-45**

Background: Diabetes is a chronic illness, which requires the individual to assume responsibility for their own care with the aim of maintaining glucose and blood pressure levels as close to normal as possible. Traditionally self-management training for diabetes has been delivered in a didactic manner. In recent times alternatives to the traditional delivery of diabetes care have been investigated, for example, the concept of peer support which emphasises patient rather than professional domination. This paper describes the pilot study and protocol for a study that aims to evaluate the effectiveness of a peer support intervention for people with type 2 diabetes in a primary care setting. Methods/Design: A pilot study was conducted to assess the feasibility of a randomized controlled trial of a peer support intervention. We used the MRC Framework for the evaluation of complex interventions. Elements of the intervention were defined and the study protocol was finalized. In this cluster randomised controlled trial twenty general practices are assigned to control and intervention groups. Each practice compiles a diabetes register and randomly selects 21 patients. All practices implement a standardised diabetes care system. In the intervention group all practices recruit three peer supporters. The peer supporters are trained to conduct nine group meetings in their general practice over a period of two years. Each meeting has a structured component. The primary outcomes are blood pressure, total cholesterol, HbA1c and the Diabetes Well-being score. In addition to biophysical, psychosocial, economic and health service utilization data peer supporter activity and qualitative data are collected. Discussion: Peer support is a complex intervention and evaluating such an intervention presents challenges to researchers. This study will evaluate whether a peer support programme for patients with type 2 diabetes improves biophysical and psychosocial outcomes and whether it is an acceptable, cost effective intervention in the primary care setting. Trial Registration: Current Controlled Trials ISRCTN42541690

**Peel E, Douglas M, Lawton J. Self monitoring of blood glucose in type 2 diabetes: longitudinal qualitative study of patients' perspectives. *British Medical Journal* 2007 335 (7618) 493- DOI: 10.1136/bmj.39302.444572.DE**

Objective: To explore views of patients with type 2 diabetes about self monitoring of blood glucose over time. Design: Longitudinal, qualitative study. Setting: Primary and secondary care settings across Lothian, Scotland. Participants: 18 patients with type 2

diabetes. Main outcome measures: Results from repeat in-depth interviews with patients over four years after clinical diagnosis. Results: Analysis revealed three main themes-the role of health professionals, interpreting readings and managing high values, and the ongoing role of blood glucose self monitoring. Self monitoring decreased over time, and health professionals' behaviour seemed crucial in this: participants interpreted doctors' focus on levels of haemoglobin A(1c), and lack of perceived interest in meter readings, as indicating that self monitoring was not worth continuing. Some participants saw readings as a proxy measure of good and bad behaviour-with women especially, chastising themselves when readings were high. Some participants continued to find readings difficult to interpret, with uncertainty about how to respond to high readings. Reassurance and habit were key reasons for continuing. There was little indication that participants were using self monitoring to effect and maintain behaviour change. Conclusions: Clinical uncertainty about the efficacy and role of blood glucose self monitoring in patients with type 2 diabetes is mirrored in patients' own accounts. Patients tended not to act on their self monitoring results, in part because of a lack of education about the appropriate response to readings. Health professionals should be explicit about whether and when such patients should self monitor and how they should interpret and act upon the results, especially high readings

**Scherer, M et al      Psychological distress in primary care patients with heart failure: a longitudinal study    *British Journal of General Practice*    October 2007 57 (543) 801-807**

Background: Psychological distress is a common phenomenon in patients with heart failure. Depressive symptoms are often under-diagnosed or inadequately treated in primary care. Aim: To analyse anxiety and/or depression in primary care patients with heart failure according to psychosocial factors, and to identify protective factors for the resolution of psychological distress. Design of study: Longitudinal observation study. Setting: Primary care practices in lower Saxony, Germany. Method: In 291 primary care patients with heart failure the following factors were measured using validated questionnaires at baseline and 9 months later: anxiety and depression (Hospital Anxiety and Depression Scale [HADS]), quality of life (Minnesota Living with Heart Failure Questionnaire), coping with illness (Freiburg questionnaire for coping with illness), and social support (social support questionnaire). Severity of heart failure (New York Heart Association [NYHA] classification and Goldman's Specific Activity Scale), and sociodemographic characteristics were documented using self-report instruments. Results: Twenty-six (32.5%) of the 80 patients who were distressed at baseline had normal HADS scores 9 months later, while the remainder stayed distressed. In logistic regression, baseline distress (odds ratios [OR] 5.51; 95% confidence intervals [CI] = 2.56 to 11.62), emotional problems (OR = 1.08; 95% CI = 1.00 to 1.17), social support (OR = 0.54; 95% CI = 0.35 to 0.83), and NYHA classification (OR = 1.70; 95% CI = 1.05 to 2.77) independently predicted distress at follow up. High social support contributed to a resolution of anxiety or depression, while partnership and low levels of emotional problems protected patients who began the study in a good emotional state from psychological distress. Conclusion: In everyday practice it is important to consider that a

high NYHA classification and emotional problems may contribute to anxiety or depression, while high social support and living in a relationship may positively influence the psychological health of patients with heart failure.

**Taylor CR, et al** Effect of crew resource management on diabetes care and patient outcomes in an inner-city primary care clinic. *Quality and Safety in Health Care* 2007 16 (4) :244-7 DOI: 10.1136/qshc.2006.019042

Background: Diabetes care in our inner-city primary care clinic was suboptimal, despite provider education and performance feedback targeting improved adherence to evidence-based clinical guidelines. A crew resource management (CRM) intervention (communication and teamwork, process and workflow organisation, and standardised information debriefings) was implemented to improve diabetes care and patient outcomes. Objective: To assess the effect of the CRM intervention on adherence to evidence-based diabetes care standards, work processes, standardised clinical communication and patient outcomes. Methods: Time-series analysis was used to assess the effect on the delivery of standard diabetes services and patient outcomes among medically indigent adults (n = 619). Results: The CRM principles were translated into useful process redesign and standardised care approaches. Significant improvements in microalbumin testing and associated patient outcome measures were attributed to the intervention. Conclusions: The CRM approach provided tools for management that, in the short term, enabled reorganisation and prevention of service omissions and, in the long term, can produce change in the organisational culture for continuous improvement

**Van Shaik D JF, et al.** Interpersonal psychotherapy (IPT) for late-life depression in general practice: uptake and satisfaction by patients, therapists and physicians. *BMC Family Practice* 2007 8.52 DOI: 10.1186/1471-2296-8-52

Background Interpersonal Psychotherapy (IPT) is recommended in most depression treatment guidelines and proved to be a suitable treatment for elderly depressed patients. Despite the favorable results of IPT in research populations, the dissemination to general practice is surprisingly limited. Little is known about uptake and satisfaction when this therapy is introduced into real-life general practice. Methods Motivation and evaluation of patients, GPs and therapists were recorded and organisational barriers described, alongside a randomised controlled trial. IPT, given by mental health workers, was compared with usual general practitioner (GP) care. Included were patients (55 years or older) who met the DSM-IV criteria for major depressive disorder. Results Patients were motivated for the psychotherapy intervention: of the 205 eligible patients, 143 (70%) entered the study, and of the 69 patients who were offered IPT, 77% complied with the treatment. IPT proved to be an attractive therapy for patients as well as for therapists from mental health organizations. General practitioners evaluated the intervention positively afterwards, mainly because of the time-limited and structured approach. Organizational barriers: no IPT therapists were available; an IPT trainer and supervisor had to be trained and training materials had to be developed and translated.

Additionally, there was a lack of office space in some general practices; for therapists from private practices it was not feasible to participate because of financial reasons. IPT was superior to usual care in patients with moderate to severe depression. Conclusions As we succeeded in delivering IPT in primary care practice, and as IPT was superior to usual care, there are grounds to support the implementation of IPT for depressed elderly patients within general practice, as long as the practices have room for the therapists and financial barriers can be overcome. Consolidation may be achieved by making this intervention available through practice nurses or community psychiatric nurses who deliver IPT as part of a more comprehensive depression management program.

**Zhang X, et al The Effects of Interventions on Health-Related Quality of Life Among Persons With Diabetes: A Systematic Review. *Medical Care* 2007 45 (9) 820-34. DOI: 10.1097/MLR.0b013e3180618b55**

Background:: Health-related quality of life (HRQL) is increasingly used to measure the outcomes of interventions among people with chronic diseases. Objectives:: To assess the effect of interventions for adults with diabetes on HRQL, as measured by the Short Form (SF)-36 questionnaire. Research design:: The systematic review was conducted using the methods of the Cochrane Collaboration. Studies reporting SF-36 scores before and after an intervention focused on adults with diabetes were obtained from searches of multiple bibliographic databases. The mean changes and standardized mean differences between pre- and post-intervention were reported as outcome measures. Pooled estimates were obtained using random effects models. Results:: We identified 33 studies examining a wide range of interventions, including diabetes education and behavioral modifications (15 studies), pharmacotherapy (11 studies), and surgery (7 studies). Interventions generally demonstrated improvement in HRQL. When all available profile scores were examined together, the ranges of mean changes in scores were as follows: surgery for treating diabetes comorbidities, 15.0 to 42.0 point improvement; surgery for treating diabetes complications, -13.0 to 37.9; pharmacotherapy using insulin to optimize glycemic control, -4.6 to 27.6; pharmacotherapy for treating comorbidities, 3.8 to 33.2; pharmacotherapy for treating complications, -2.6 to 14.6. Pooled effects from 5 randomized controlled trials of educational interventions demonstrated significantly improved physical function [3.4 (95% CI, 0.1-6.6)] and mental health [4.2 (95% CI, 1.8-6.6)], and a decrease in bodily pain [3.6 (95% CI, 0.6-6.7)]. Conclusions:: A variety of interventions can improve HRQL among adults with diabetes, but the magnitude of effects varied with the interventions. The mechanism of these changes needs to be further examined in the future research

**Zweifler, J The missing link: improving quality with a chronic disease management intervention for the primary care office *Annals of Family Medicine* Sep-Oct 2007 5 (5) 453-456 DOI: 10.1370/afm.745**

Bold steps are necessary to improve quality of care for patients with chronic diseases and increase satisfaction of both primary care physicians and patients. Office-based chronic disease management (CDM) workers can achieve these objectives by offering self-

management support, maintaining disease registries, and monitoring compliance from the point of care. CDM workers can provide the missing link by connecting patients, primary care physicians, and CDM services sponsored by health plans or in the community. CDM workers should be supported financially by Medicare, Medicaid, and commercial health plans through reimbursements to physicians for units of service, analogous to California's Comprehensive Perinatal Services Program. Care provided by CDM workers should be standardized, and training requirements should be sufficiently flexible to ensure wide dissemination. CDM workers can potentially improve quality while reducing costs for preventable hospitalizations and emergency department visits, but evaluation at multiple levels is recommended.

## EVIDENCE BASED MEDICINE

**Glasby J What counts as "evidence" in 'evidence-based practice'? *Evidence & Policy* 2007 3 (3) 325-327**

This issue features 6 papers generated by a series of seminars sponsored by the Economic and Social Research Council which aimed to bring together academics, postgraduate research students and users of research throughout the UK with an interest in developing new ways of knowing the world that combine different types of evidence. The following papers are included : What counts as 'evidence' in 'evidence-based practice'? Authors: *Glasby, Jon; Walshe, Kieran; Harvey, Gill* , The role of service user research in generating knowledge-based health and social care: from conflict to contribution Author: *Beresford, Peter* , Whose lives and whose learning? Whose narratives and whose writing? Taking the next research and literature steps with experts by experience Author: *Preston-Shoot, Michael* , Testing methodological developments in the conduct of narrative synthesis: a demonstration review of research on the implementation of smoke alarm interventions

Authors: *Arai, Lisa; Britten, Nicky; Popay, Jennie; Roberts, Helen; Petticrew, Mark; Rodgers, Mark; Sowden, Amanda* , Promoting the use of diverse sources of evidence: evaluating progress in the provision of services for people with dementia and their carers Authors: *Moriarty, Jo; Manthorpe, Jill; Iliffe, Steve; Rapaport, Joan; Clough, Roger; Bright, Les; Cornes, Michelle* ,

The quality of research evidence in social policy: consensus and dissension among researchers, Authors: *Sempik, Joe; Becker, Saul; Bryman, Alan* , Making evidence fit for purpose in decision making: a case study of the hospital discharge of older people Authors: *Glasby, Jon; Walshe, Kieran; Harvey, Gill* , *Using evidence: How research can inform public services*: a review Author: *Grayson, Lesley* . The conclusions of the series suggest different approaches are needed depending on the policy question and that reviewing a range of diverse sources may often be a better way forward than a single, method-led approach. Designing deliberative processes to synthesise and integrate evidence from different sources is needed to inform decision making in health and social care.

## HEALTH ECONOMICS

Allan GM; Lexchin J; Wiebe N Physician Awareness of Drug Cost: A Systematic Review *Plos Medicine* e283 25/9/2007 4:9 DOI: 10.1371/journal.pmed.0040283

**Background** Pharmaceutical costs are the fastest-growing health-care expense in most developed countries. Higher drug costs have been shown to negatively impact patient outcomes. Studies suggest that doctors have a poor understanding of pharmaceutical costs, but the data are variable and there is no consistent pattern in awareness. We designed this systematic review to investigate doctors' knowledge of the relative and absolute costs of medications and to determine the factors that influence awareness.

**Methods and Findings** Our search strategy included The Cochrane Library, EconoLit, EMBASE, and MEDLINE as well as reference lists and contact with authors who had published two or more articles on the topic or who had published within 10 y of the commencement of our review. Studies were included if: either doctors, trainees (interns or residents), or medical students were surveyed; there were more than ten survey respondents; cost of pharmaceuticals was estimated; results were expressed quantitatively; there was a clear description of how authors defined "accurate estimates"; and there was a description of how the true cost was determined. Two authors reviewed each article for eligibility and extracted data independently. Cost accuracy outcomes were summarized, but data were not combined in meta-analysis because of extensive heterogeneity. Qualitative data related to physicians and drug costs were also extracted. The final analysis included 24 articles. Cost accuracy was low; 31% of estimates were within 20% or 25% of the true cost, and fewer than 50% were accurate by any definition of cost accuracy. Methodological weaknesses were common, and studies of low methodological quality showed better cost awareness. The most important factor influencing the pattern and accuracy of estimation was the true cost of therapy. High-cost drugs were estimated more accurately than inexpensive ones (74% versus 31%, Chi-square  $p < 0.001$ ). Doctors consistently overestimated the cost of inexpensive products and underestimated the cost of expensive ones (binomial test, 89/101,  $p < 0.001$ ). When asked, doctors indicated that they want cost information and feel it would improve their prescribing but that it is not accessible.

**Conclusions** Doctors' ignorance of costs, combined with their tendency to underestimate the price of expensive drugs and overestimate the price of inexpensive ones, demonstrate a lack of appreciation of the large difference in cost between inexpensive and expensive drugs. This discrepancy in turn could have profound implications for overall drug expenditures. Much more focus is required in the education of physicians about costs and the access to cost information. Future research should focus on the accessibility and reliability of medical cost information and whether the provision of this information is used by doctors and makes a difference to physician prescribing. Additionally, future work should strive for higher methodological standards to avoid the biases we found in the current literature, including attention to the method of assessing accuracy that allows larger absolute estimation ranges for expensive drugs.

**Bachmann MO, et al. Methods for analyzing cost effectiveness data from cluster randomized trials** *Cost Effectiveness and Resource Allocation* 2007 5:12 6/9/2007  
DOI: 10.1186/1478-7547-5-12

**Background** Measurement of individuals' costs and outcomes in randomized trials allow uncertainty about cost effectiveness to be quantified. Uncertainty is expressed as probabilities that an intervention is cost effective, and confidence intervals of incremental cost effectiveness ratios. Randomizing clusters instead of individuals tends to increase uncertainty but such data are often analysed incorrectly in published studies. **Methods** We used data from a cluster randomized trial to demonstrate five appropriate analytic methods: 1) joint modeling of costs and effects with two-stage non-parametric bootstrap sampling of clusters then individuals, 2) joint modeling of costs and effects with Bayesian hierarchical models and 3) linear regression of net benefits at different willingness to pay levels using a) least squares regression with Huber-White robust adjustment of errors, b) a least squares hierarchical model and c) a Bayesian hierarchical model. **Results** All five methods produced similar results, with greater uncertainty than if cluster randomization was not accounted for. **Conclusions** Cost effectiveness analyses alongside cluster randomized trials need to account for study design. Several theoretically coherent methods can be implemented with common statistical software.

**Dusheiko M et al Explaining trends in concentration of healthcare commissioning in the English NHS** *Health Economics* 12/10/2007 Epub ahead of print DOI: 10.1002/hec.1301

In recent years there have been marked changes in organisational structures and budgetary arrangements in the English National Health Service, potentially altering the relationships between purchasers (primary care organisations (PCOs) and general practices) and hospitals. We show that elective admissions from PCOs and practices became significantly more concentrated across hospitals between 1997/98 and 2002/03. There was a reduction in the average number of hospitals used by PCOs (16.7-14.2), an increase in the average share of admissions accounted for by the main hospital (49-69%), and an increase in the average Herfindahl index (0.35-0.55). About half the increase in concentration arose from the increase in the number of purchasing organisations as 100 health authorities were replaced by 303 primary care trusts. Most of the remainder was probably due to hospital mergers. Fundholding general practices that held budgets for elective admissions had less concentrated admission patterns than non-fundholders whose admissions were paid for by their PCO. Around 1/10th of the increase in concentration at practice level was due to the abolition of fundholding in April 1999. Our results have implications for the effects of the recent reintroduction of fundholding and the halving of the number of PCOs.

**Felt-Lisk S, Gimm G, Peterson S. Making pay-for-performance work in Medicaid. *Health Affairs (Millwood.)* 2007 26 (4) w516-w527 DOI: 10.1377/hlthaff.26.4.w516**

Findings from a Medicaid pay-for-performance (P4P) demonstration suggest that "money talks" only sometimes, when supportive program elements give it voice. In this paper we examine five Medicaid-focused health plans that implemented new financial incentives for physicians to improve the timeliness of well-baby care. By contrasting the experiences of plans with better and worse outcome trends, we identify key program features--including strong communication with providers and placing enough dollars at stake to compensate providers for the effort required to obtain them--taking into account the starting point. The findings also highlight barriers to improvement that future Medicaid P4P efforts should consider

**Hanratty B et al Are the best available clinical effectiveness data used in economic evaluations of drug therapies? *Journal of Health Services Research and Policy* 2007 12 (3) 138-41. DOI: 10.1258/135581907781543067**

Objectives: Use of evidence on clinical effectiveness that is of poor quality or is biased in favour of the therapy under study is a concern in economic evaluations and may contribute to a mistrust of pharmacoeconomic studies. This study aimed to determine whether the authors of economic evaluations use the best available evidence for clinical effectiveness. Methods: One hundred economic evaluations of drug therapies (published in 2001-2003) were sampled randomly from the National Health Service Economic Evaluation Database, and the source of clinical evidence was identified. For each therapy, alternative, high quality sources of clinical effectiveness data were sought by searching the Database of Abstracts of Reviews of Effects and Health Technology Assessment databases. The magnitude and direction of the effect size in the different sources of evidence were compared. Results: Relevant systematic reviews were found for only 32 of the 100 economic evaluations in the sample. In three cases these reviews had been identified by the authors of the economic evaluations and two of these cases were used in the evaluation. Comparisons were possible in 21 cases. The clinical effects reported in all 21 comparisons were similar in direction but differed in magnitude. Compared to the systematic reviews, the authors of economic evaluations used evidence that was more favourable in five cases, less favourable in four cases, and similar in 12 cases. Six of the economic evaluations and corresponding systematic reviews did not present measures of effectiveness in a manner that allowed comparison. Conclusions: Authors of economic evaluations have not made sufficient use of the evidence available from systematic reviews of clinical effectiveness. The central role of economic evaluations in health policy makes it essential that improvements in economic methods are accompanied by a structured search for the highest quality information on clinical effectiveness

**Hsiao WC. Why is a systemic view of health financing necessary? *Health Affairs (Millwood.)* 2007 26 (4) 950-61 DOI: 10.1377/hlthaff.26.4.950**

The mobilization of funds for health care has gained prominent attention around the world. Billions of dollars in new funds are flowing into health care in low- and middle-income countries. Sadly, this money might not be transformed into efficient and effective health care to help poor and vulnerable people in these countries unless nations take a systemic approach to health care financing. This paper outlines key health policy issues and argues that choosing health care financing methods with integrated institutional arrangements and payment systems is critical to providing equitable, efficient, and effective health care for all

**O'Reilly D et al Patients' attitudes to co-payments for general practitioner services: do they reflect the prevailing system? *Journal of Health Services Research and Policy* October 2007 12 (4) 197-201 DOI: 10.1258/135581907782101589**

Objectives: Most Organisation for Economic Co-operation and Development (OECD) countries have introduced cost-sharing. This study compares the views of patients who are used to a service that is free at the point of delivery with those who are used to a system where 70% of patients pay for consultations. Methods: Secondary analysis of survey data from a random sample of 11,870 patients in Northern Ireland and the Republic of Ireland. Results: A 52% response rate was achieved, though respondents were representative of the two populations. Attitudes generally reflected the national status quo with little support for co-payments where there was currently no charging, but broad support where charging was established. Charging for missed appointments would be supported where there were delays in getting an appointment. Conclusions: More research is needed to understand what underlies support for, or opposition to, charges. However, it is apparent that patients' opinions need to be considered when formulating health care policy.

**Savedoff WD. What should a country spend on health care? *Health Affairs (Millwood.)* 2007 26 (4) 962-70 DOI: 10.1377/hlthaff.26.4.962I:**

Per capita health spending across countries ranges by more than 100 to 1, leading many people to ask, "What should a country spend on health care?" This paper discusses four approaches to this question and demonstrates how each approach, in effect, answers a slightly different question, all of which are important to public policy decisions regarding health care spending. The paper also addresses a commonly cited World Health Organization statement that countries should spend 5 percent of national income on health care services

## HEALTH INEQUALITIES

**Cox M, et al. Does health-selective migration following diagnosis strengthen the relationship between Type 2 diabetes and deprivation? *Social Science and Medicine* 2007; 65 (1) 32-42. DOI: 10.1016/j.socscimed.2007.02.045**

Geographical health inequalities have been demonstrated for Type 2 diabetes in many developed countries, with poorer areas tending to have higher rates than wealthier areas. Previous studies have considered diabetes prevalence, relying on cross-sectional data collected from registers or hospital admissions records. However, the environment that had most influence on the development of a person's diabetes may not have been the same environment in which they are identified in a prevalence study. We therefore investigate whether health selective migration confounds the relationship between diabetes and deprivation by following a cohort of Type 2 diabetics from diagnosis until the end of the study, 8-18 years later. Our results demonstrate, first, that there is a significant relationship between material deprivation and diabetes incidence. Secondly, Type 2 diabetics in Tayside, Scotland have become more concentrated in relatively more deprived areas over time, strengthening the relationship between diabetes and material deprivation. Thirdly, and perhaps unexpectedly, this strengthening effect results primarily from selective immobility, rather than selective migration. We conclude that care should be taken when evaluating the relationship between diabetes and deprivation in cross-sectional studies.

**Strong M, et al. A method for modelling GP practice level deprivation scores using GIS. *International Journal of Health Geographics* 2007 6.38 DOI: 10.1186/1476-072X-6-38**

Background: A measure of general practice level socioeconomic deprivation can be used to explore the association between deprivation and other practice characteristics. An area-based categorisation is commonly chosen as the basis for such a deprivation measure. Ideally a practice population-weighted area-based deprivation score would be calculated using individual level spatially referenced data. However, these data are often unavailable. One approach is to link the practice postcode to an area-based deprivation score, but this method has limitations. This study aimed to develop a Geographical Information Systems (GIS) based model that could better predict a practice population-weighted deprivation score in the absence of patient level data than simple practice postcode linkage. Results: We calculated predicted practice level Index of Multiple Deprivation (IMD) 2004 deprivation scores using two methods that did not require patient level data. Firstly we linked the practice postcode to an IMD 2004 score, and secondly we used a GIS model derived using data from Rotherham, UK. We compared our two sets of predicted scores to "gold standard" practice population-weighted scores for practices in Doncaster, Havering and Warrington. Overall, the practice postcode linkage method overestimated "gold standard" IMD scores by 2.54 points (95% CI 0.94,

4.14), whereas our modelling method showed no such bias (mean difference 0.36, 95% CI -0.30, 1.02). The postcode-linked method systematically underestimated the gold standard score in less deprived areas, and overestimated it in more deprived areas. Our modelling method showed a small underestimation in scores at higher levels of deprivation in Havering, but showed no bias in Doncaster or Warrington. The postcode-linked method showed more variability when predicting scores than did the GIS modelling method. Conclusions: A GIS based model can be used to predict a practice population-weighted area-based deprivation measure in the absence of patient level data. Our modelled measure generally had better agreement with the population-weighted measure than did a postcode-linked measure. Our model may also avoid an underestimation of IMD scores in less deprived areas, and overestimation of scores in more deprived areas, seen when using postcode linked scores. The proposed method may be of use to researchers who do not have access to patient level spatially referenced data.

**Soljak M A Ethnic inequalities in the treatment and outcome of diabetes in three English Primary Care Trusts *International Journal for Equity in Health* 2/8/2007 6:8 DOI: 10.1186/1475-9276-6-8**

Background: Although the prevalence of diabetes is three to five times higher in UK South Asians than Whites, there are no reports of the extent of ethnicity recording in routine general practice, and few population-based published studies of the association between ethnicity and quality of diabetes care and outcomes. We aimed to determine the association between ethnicity and healthcare factors in an English population. Methods: Data was obtained in 2002 on all 21,343 diabetic patients registered in 99% of all computerised general practitioner (GP) practices in three NW London Primary Care Trusts (PCTs), covering a total registered population of 720,000. Previously practices had been provided with training, data entry support and feedback. Treatment and outcome measures included drug treatment and blood pressure (BP), total cholesterol and haemoglobin A1c (HbA1c) levels. Results: Seventy per cent of diabetic patients had a valid ethnicity code. In the relatively older White population, we expected a smaller proportion with a normal BP, but BP differences between the groups were small and suggested poorer control in non-White ethnic groups. There were also significant differences between ethnic groups in the proportions of insulin-treated patients, with a smaller proportion of South Asians - 4.7% compared to 7.1% of Whites - receiving insulin, although the proportion with a satisfactory HbA1c was smaller- 25.6% compared to 37.9%. Conclusion: Recording the ethnicity of existing primary care patients is feasible, beginning with patients with established diseases such as diabetes. We have shown that the lower proportion of South Asian patients with good diabetes control, and who are receiving insulin, is at least partly due to poorer standards of care in South Asians, although biological and cultural factors could also contribute. This study highlights the need to capture ethnicity data in clinical trials and in routine care, to specifically investigate the reasons for these ethnic differences, and to consider more intensive management of diabetes and education about the disease in South Asian patients.

## HEALTH POLICY

**Salter B. Governing UK medical performance: A struggle for policy dominance.**  
*Health Policy* 2007; 82 (3) 263-75 DOI: 10.1016/j.healthpol.2006.10.004

In the UK, policy on the governance of medical performance is characterised by a continuing struggle between state and profession for control of the agenda setting, formation and implementation stages of the policy process. Since 1998 both sides have continued to produce policies in response to highly visible political pressures but have yet to agree on how those policies should engage as they are implemented at the level of the individual practitioner. For the state, clinical governance forms the lynchpin of its drive to increase managerial control over doctors and, for the profession, revalidation is seen as the means for ensuring the quality of medical performance whilst preserving medicine's historic autonomy. This paper analyses the course of this 7-year struggle and shows how in constructing and delivering policy, state and profession draw on quite different and separate sets of institutional structures and values. As a consequence, there is an unresolved competition for dominance and little engagement between the two policy streams.

**Sullivan E et al Primary healthcare teams' views on using mortality data to review clinical policies** *Quality and Safety in Health Care* 2007 16 (5) 359-362 DOI: 10.1136/qshc.2006.022111

Background and objective: A UK-wide scheme to monitor mortality in general practices has been recommended to improve safety. A monitoring scheme might also have a role in improving quality by informing clinical policies. This study investigated the views of primary care teams on the desirable characteristics of mortality data to help them review and plan their clinical policies. Setting: 10 general practices in Leicestershire, UK. Methods: Development of a format for presentation of mortality data for primary care teams, presentations of the data to team meetings, and subsequent interviews of 16 general practitioners and nurses to identify issues about the improvement and use of the data for informing clinical policies. Results: The presentation was important in helping teams to understand the data. Comparisons should be between practices with similar patient populations, and information provided on deaths from diseases potentially amenable to prevention through clinical intervention. Practice teams used the data in reflecting on their own clinical care. Conclusions: Presentation of data about mortality in practice populations can enable practices to reflect on their clinical policies. The proposed national scheme for monitoring mortality should provide data in a format that helps teams to improve the quality of care as well as improve patient safety.

## INFORMATION TECHNOLOGY IN HEALTH CARE

**Protheroe J et al. Effectiveness of a computerised decision aid in primary care on decision making and quality of life in menorrhagia: results of the MENTIP randomized controlled trial** *Medical Decision Making* 2007 27 575-584 DOI: 10.1177/0272989X07306785

Background: To evaluate whether the addition of a computerized decision aid to written information improves decision making in women consulting their general practitioner with menorrhagia compared with written information alone. Design: of Study. Randomized controlled trial. Setting. Nineteen general practices in the North of England. Method: One hundred forty-nine women presenting with menorrhagia were randomized to receive written information and access to a computerized decision aid or written information alone. Outcomes were assessed using postal questionnaires. These were scores on the Decisional Conflict Scale and State-Trait Anxiety Inventory anxiety scale at 2 weeks and the Menorrhagia Specific Utility quality-of-life scale, knowledge about menorrhagia, and anxiety and process measures at 6 months. Results: Two weeks after the intervention, there was significantly less decisional conflict in the intervention group (adjusted difference=-16.6; 95% confidence interval [CI]=-21.5 to -11.7; P<0.001). At 6 months, the intervention group showed better knowledge about menorrhagia (adjusted difference=9.3; 95% CI=1.9 to 16.6; P=0.014) and menorrhagia quality of life (adjusted difference=10.9; 95% CI=0.9 to 21.0; P=0.033). There was no difference in anxiety scores at either 2 weeks or 6 months. Conclusions: A computerized decision aid, used outside of the primary care consultation, is effective in increasing patient involvement in decision making in primary care.

## MEDICINES MANAGEMENT

**Allan GM; Lexchin J; Wiebe N Physician awareness of drug cost: a systematic review** *Plos Medicine* 9/10/2007 4:9 DOI: 10.1371/journal.pmed.0040283

Background Pharmaceutical costs are the fastest-growing health-care expense in most developed countries. Higher drug costs have been shown to negatively impact patient outcomes. Studies suggest that doctors have a poor understanding of pharmaceutical costs, but the data are variable and there is no consistent pattern in awareness. We designed this systematic review to investigate doctors' knowledge of the relative and absolute costs of medications and to determine the factors that influence awareness. Methods and Findings Our search strategy included The Cochrane Library, EconoLit, EMBASE, and MEDLINE as well as reference lists and contact with authors who had published two or more articles on the topic or who had published within 10 y of the commencement of our review. Studies were included if: either doctors, trainees (interns or residents), or medical students were surveyed; there were more than ten survey

respondents; cost of pharmaceuticals was estimated; results were expressed quantitatively; there was a clear description of how authors defined “accurate estimates”; and there was a description of how the true cost was determined. Two authors reviewed each article for eligibility and extracted data independently. Cost accuracy outcomes were summarized, but data were not combined in meta-analysis because of extensive heterogeneity. Qualitative data related to physicians and drug costs were also extracted. The final analysis included 24 articles. Cost accuracy was low; 31% of estimates were within 20% or 25% of the true cost, and fewer than 50% were accurate by any definition of cost accuracy. Methodological weaknesses were common, and studies of low methodological quality showed better cost awareness. The most important factor influencing the pattern and accuracy of estimation was the true cost of therapy. High-cost drugs were estimated more accurately than inexpensive ones (74% versus 31%, Chi-square  $p < 0.001$ ). Doctors consistently overestimated the cost of inexpensive products and underestimated the cost of expensive ones (binomial test, 89/101,  $p < 0.001$ ). When asked, doctors indicated that they want cost information and feel it would improve their prescribing but that it is not accessible. Conclusions Doctors' ignorance of costs, combined with their tendency to underestimate the price of expensive drugs and overestimate the price of inexpensive ones, demonstrate a lack of appreciation of the large difference in cost between inexpensive and expensive drugs. This discrepancy in turn could have profound implications for overall drug expenditures. Much more focus is required in the education of physicians about costs and the access to cost information. Future research should focus on the accessibility and reliability of medical cost information and whether the provision of this information is used by doctors and makes a difference to physician prescribing. Additionally, future work should strive for higher methodological standards to avoid the biases we found in the current literature, including attention to the method of assessing accuracy that allows larger absolute estimation ranges for expensive drugs.

**Denneboom W, et al Treatment reviews of older people on polypharmacy in primary care: cluster controlled trial comparing two approaches. *British Journal of General Practice* 2007 57 723-31.**

Background: Older people are prone to problems related to use of medicines. As they tend to use many different medicines, monitoring pharmacotherapy for older people in primary care is important. AIM: To determine which procedure for treatment reviews (case conferences versus written feedback) results in more medication changes, measured at different moments in time. To determine the costs and savings related to such an intervention. Design of study: Randomised, controlled trial, randomisation at the level of the community pharmacy. Setting: Primary care; treatment reviews were performed by 28 pharmacists and 77 GPs concerning 738 older people ( $\geq 75$  years) on polypharmacy ( $> 5$  medicines). Method: In one group, pharmacists and GPs performed case conferences on prescription-related problems; in the other group, pharmacists provided results of a treatment review to GPs as written feedback. Number of medication changes was counted following clinically-relevant recommendations. Costs and savings associated with the intervention at various times were calculated. Results: In the case-conference group significantly more medication changes were initiated (42 versus 22,  $P =$

0.02). This difference was also present 6 months after treatment reviews (36 versus 19,  $P = 0.02$ ). Nine months after treatment reviews, the difference was no longer significant (33 versus 19,  $P = 0.07$ ). Additional costs in the case-conference group seem to be covered by the slightly greater savings in this group. Conclusion: Performing treatment reviews with case conferences leads to greater uptake of clinically-relevant recommendations. Extra costs seem to be covered by related savings. The effect of the intervention declines over time, so performing treatment reviews for older people should be integrated in the routine collaboration between GPs and pharmacists

**Spurling G, Mansfield P. General practitioners and pharmaceutical sales representatives: quality improvement research. *Quality and Safety in Health Care* 2007 16 (4) 266-70 DOI: 10.1136/qshc.2006.020164**

Background and objective: Interaction between pharmaceutical sales representatives (PSRs) and general practitioners (GPs) may have an adverse impact on GP prescribing and therefore may be ethically questionable. This study aimed to evaluate the interactions between PSRs and GPs in an Australian general practice, and develop and evaluate a policy to guide the interaction. Methods: Doctors' prescribing, diaries, practice promotional material and samples were audited and a staff survey undertaken. After receiving feedback, the staff voted on practice policy options. The resulting policy was evaluated 3 and 9 months. Results: Prior to the intervention, GPs spent on average 40 min/doctor/month with PSRs. There were 239 items of promotional material in the practice and 4660 tablets in the sample cupboard. These were reduced by 32% and 59%, respectively, at 3 months after policy adoption and the reduction was sustained at 9 months. Vioxx was the most common drug name in promotional material. Staff adopted a policy of reduced access to PSRs including: reception staff not to make appointments for PSRs or accept promotional material; PSRs cannot access sample cupboards; GPs wishing to see PSRs may do so outside consulting hours. At 3 and 9 months, most staff were satisfied with the changes. Promotional items/room were not significantly reduced at 3 months (-4.0 items/room ; 95% CI -6.61 to -1.39;  $p = 0.066$ ) or 9 months (-2.63 items/room; 95% CI -5.86 to 0.60;  $p = 0.24$ ). Generic prescribing significantly increased at 3 months (OR 2.28, 95% CI 1.31 to 3.86;  $p = 0.0027$ ) and 9 months (OR 2.07, 95% CI 1.13 to 3.82;  $p = 0.016$ ). Conclusion: There was a marked reduction in interactions with PSRs with majority staff satisfaction and improved prescribing practices. The new policy will form part of the practice's orientation package. Reception staff give PSRs a letter explaining the policy. It is hoped that the extra 40 min/doctor of consulting time translates into more time with patients and time to evaluate more independent sources of drug information

## **MENTAL HEALTH**

**Aragones E, Pinol JL, Labad A, Depression and physical comorbidity in primary care. *Journal of Psychosomatic Research* 2007 63 (2) 107-111 DOI: 10.1016/j.jpsychores.2007.05.008**

Objective: To analyse how clinical characteristics in depressed patients, as well as the management of their depression, are related to the presence of significant physical comorbidity. Methods: This is a two-phase cross-sectional study that took place in 10 primary care centres in Tarragona (Spain). A total of 906 consecutive patients were screened for depression with a self-rating questionnaire and 306 were subject to a structured interview that contained the diagnoses of major depression and dysthymia (DSM-IV), and the severity of the physical comorbidity (Duke Severity of Illness Scale: DUSOI). The association of several clinical variables with the presence of physical comorbidity was evaluated. Results: The comorbidity was of moderate to extreme severity (DUSOI >50) in 31.7% of cases. The patients with comorbidity visited the physician more often. There were no differences in the consumption of antidepressants, reason for the consultation (psychological/somatic), or the probability of being detected as depressed. Neither were there any differences in the severity or disability between both groups. Conclusion: Physical comorbidity is frequent in primary care depressed patients. In general, the characteristics of depression and the handling by the doctor are similar in patients with and without comorbidity.

**Bjaertnaes OA, Garratt A, Nessa J, The GPs' Experiences Questionnaire (GPEQ): Reliability and validity following a national survey to assess GPs' views of district psychiatric services *Family Practice* August 2007 24 (4) 336-342 DOI: 10.1093/fampra/cmm025**

Background. The measurement of patient and professional views of quality are important components in the evaluation of health care delivery. Objective. To describe the development and evaluation of the GPs' Experiences Questionnaire (GPEQ) for assessing the quality of community mental health clinics in Norway. Methods. Design: Literature review, GP interviews, pre-testing of questionnaire items and a cross-sectional national survey. Setting: Postal survey of GPs in Norway evaluating 73 community mental health clinics in the five health regions in Norway during spring of 2006. Subjects: Three thousand four hundred and sixty-three GPs were sent a postal questionnaire with the GPEQ and were asked to assess their community mental health clinic responsible for general adult psychiatric services. Results. Two thousand one hundred and thirty (61.5%) GPs returned a completed questionnaire. Low levels of missing data suggest that the questionnaire is acceptable. Factor analysis identified five scales: workforce situation (four items), discharge letter (three items), competence (four items), guidance (three items) and emergency situations (two items). All scales met the criterion of 0.7 for Cronbach's alpha and test-retest correlations were 0.72-0.87. The results of validity testing were as hypothesized with scale scores significantly related to knowledge of the community mental health clinic, overall satisfaction, negative experiences with the clinic, waiting time and acceptance of referrals. Conclusions. The GPEQ is a self-administered questionnaire that includes the most important aspects of the GPs' experience of quality at

community mental health clinics. All scales have good evidence for internal consistency, test-retest reliability and validity.

**Boyd B, Psychosocial interventions for older people with mental health difficulties**  
*Journal of Care Services Management* 2007 1 (3) 269-278

Psychosocial interventions (PSI) for older people with mental health difficulties have not been adequately researched nor have they received emphasis in national policy. The background to this situation is explored in this paper and a strategy for local implementation is presented that includes training, PSI in service design and generating local data to facilitate implementation.

**Campbell S, Gately C. Identifying the patient perspective of the quality of mental health care for common chronic problems: a qualitative study.** *Chronic Illness* 2007 3 (1) 46-65. DOI: 10.1177/1742395307079193

Objectives: To identify which aspects of quality are important to individual patients with common chronic mild-to-moderate mental health problems presenting to general practice and the best method of involving patients with chronic mental health problems in the research process, and to contrast the relevance of a generic questionnaire developed previously with these individual patient narratives. Methods: Qualitative interviews with 16 patients in Chester and Manchester were subjected to thematic analysis. Results: Six key themes were identified in relation to the individual patient experience set against a generic patient experience: (1) the healthcare system provides a generic 'one size fits all' service, which is incompatible with an individual patient's experience and sense of being as an individual and that privileges medical over social care; (2) patients with mild-to-moderate mental health problems often have feelings of powerlessness and of being 'lost' in a system that is more responsive to severe and acute episodes of illness than to chronic morbidity; (3) patients often have unmet needs in relation to the distress of living with mild-to-moderate mental health problems; (4) there are substantial quality deficits in primary care for people with mild-to-moderate chronic mental health problems; (5) general practitioners are rated highly, and the attributes of a good general practitioner can be identified; patients also value continuity of care; (6) engaging people with common chronic mental health problems in the research/policy process requires generic assessment of quality using questionnaires supplemented with more in-depth methods, such as interviews and focus groups. Interviewees highlighted substantial quality deficits in service provision for people with chronic mental health problems. Involving patients with chronic mild-to-moderate mental health problems in the research/policy process requires multiple user involvement strategies, including questionnaires but supplemented with interviews and discussion groups. Conclusion: Patients with common chronic mental health problems have a clear view about what constitutes quality general practice/practitioner care but highlighted quality deficits for people with chronic mental health conditions.

**Cornford CS, Hill A, Reilly J How patients with depressive symptoms view their condition: a qualitative study *Family Practice* August 2007 24 (4) 358-364 DOI: 10.1093/fampra/cmm032**

Background. Depressive symptoms are common in primary care, yet considerable professional controversy exists about appropriate management including the effectiveness of treatments. In addition, avoiding prescribing antidepressants at least initially is recommended. Views of patients themselves should therefore be particularly important in agreeing management strategies. Objective. To examine lay beliefs about depressive symptoms in primary care. Method. A total of 23 semi-structured interviews were conducted with patients scoring positively for depression on the Hospital Anxiety and Depression Score in a primary care setting. Results. Differentiating 'depression' from understandable reactions to adversity was difficult for patients. The wide range of consequences discussed included adverse effects on others, difficulties coping with feeling out of control and loss of self-identity. Negative images of depression, such as depression being a 20th century phenomenon, were pervasive. Views about medication varied. Various management strategies described included strategies of detachment, engagement in activities and 'blotting out' symptoms. Conclusions. Patients' views about depressive symptoms are significantly different from conventional medical views. A 'disease management approach' fits uncomfortably with patients' experiences. Acknowledging feelings of loss of control and loss of self-identity in consultations may be useful. The wide employment of techniques patients use to control their disorders, such as support from others, engagement in activities and working at relationships, may be useful to encourage in consultations as alternatives to the use of antidepressant medication.

**Gellatly J, Bower P, et al What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychological Medicine* 2007 37 (9) 1217-28. DOI: 10.1017/S0033291707000062**

Background: Although self-help interventions are effective in treating depression, less is known about the factors that determine effectiveness (i.e. moderators of effect). This study sought to determine whether the content of self-help interventions, the study populations or aspects of study design were the most important moderators. Method: Randomized trials of the effectiveness of self-help interventions versus controls in the treatment of depressive symptoms were identified using previous reviews and electronic database searches. Data on moderators (i.e. patient populations, study design, intervention content) and outcomes were extracted and analysed using meta-regression. Results: Thirty-four studies were identified with 39 comparisons. Study design factors associated with greater effectiveness were unclear allocation concealment, observer-rated outcome measures and waiting-list control groups. Greater effectiveness was also associated with recruitment in non-clinical settings, patients with existing depression (rather than those 'at risk'), contact with a therapist (i.e. guided self-help) and the use of cognitive behavioural therapy (CBT) techniques. However, only guided self-help remained significant in the multivariate analysis [regression coefficient 0.36, 95%

confidence interval (CI) 0.05-0.68,  $p=0.03$ ]. In the subset of guided studies, there were no significant associations between outcomes and the session length, content, delivery mode or therapist background. Conclusions: The results provide some insights into moderators of self-help interventions, which might assist in the design of future interventions. However, the present study did not provide a comprehensive description, and other research methods might be required to identify factors associated with the effectiveness of self-help

**Dalsgaard T , Kallerup H, Rosendal M. Outreach visits to improve dementia care in general practice: a qualitative study. *International Journal of Quality in Health Care* 2007 19 (5) 267-73. DOI: 10.1093/intqhc/mzm033**

Background: Outreach visits reflect newer developments in adult learning theory, where the learner is actively involved in the session. Previous studies have indicated a positive effect of outreach visits on GPs' behaviour. However, the empirical role of the facilitator in the visits is poorly described. Objective: To explore general practitioners' perception of the outcome of a facilitator programme about dementia, in relation to central aspects of the facilitator's communicative role during the visits. Method: Observational studies, and focus group discussions with participating general practitioners (3 groups, 19 participants) as well as with facilitators (4 participants) in Vejle County, Denmark. Results: Facilitators drew both on a 'factual' knowledge of dementia and a more 'experience-based' knowledge when conveying programme messages. They described themselves as 'carriers of experience'. All general practitioners described an outcome of the programme, and all wished to receive a future visit by a facilitator on new topics. The outcome was described not as ground-breaking medical news, but as practical effects in terms of knowledge of dementia, motivation for working with dementia, structured assessment and management of dementia and critical reflection of established practices regarding dementia. Some general practitioners remained critical as to whether this outcome justified the resources used in the programme. The experience-based dialogue was described as central to the outcome as it linked factual knowledge to clinical practice. Conclusion: This study confirms that outreach visits contribute to the integration of factual knowledge in clinical practice, but it also underscores the importance of addressing tacit communicative practices during facilitator visits and their implications for the outcome of the programme

**Gopinath S et al Clinical factors associated with relapse in primary care patients with chronic or recurrent depression *Journal of Affective Disorders* 101 (1-3) 57-63 DOI: :10.1016/j.jad.2006.10.023**

Background: Because in most patients depression is a relapsing/remitting disorder, finding clinical factors associated with risk of relapse is important. The majority of patients with depression are treated in primary care settings, but few previous studies have examined predictors of relapse in primary care patients with recurrent or chronic depression. Methods: Data from a cohort of 386 primary care patients in a clinical trial were analyzed for clinical and demographic predictors of relapse over a one-year post-study observational period. Patients were selected for a high risk of relapse, based on a history of either 3 previous depressive episodes or dysthymia, and enrolled in a randomized trial of relapse prevention. Results: Factors found to be associated with significantly higher risk of relapse included poorer medication adherence in the 30 days prior to the trial, lower self-efficacy to manage depression, and higher scores on the Child Trauma Questionnaire. Limitations: Use of a sample of limited diversity taken from a clinical trial, and use of retrospective information from patients with potential for recall bias. Conclusions: The findings of this report suggest specific risk factors to be targeted in depression relapse prevention interventions. It is encouraging that two of the factors associated with increased risk of relapse, self-efficacy and medication adherence have been seen to improve with the intervention utilized in the primary care trial from which the studied cohort was drawn

**Haavet OR, et al    Diagnosis of depression among adolescents-- a clinical validation study of key questions and questionnaire. *BMC Family Practice* 13<sup>th</sup> July 2007    8:41. DOI: 10.1186/1471-2296-8-41**

Background: The objective of the study is to improve general practitioners' diagnoses of adolescent depression. Major depression is ranked fourth in the worldwide disability impact. Method/Design: Validation of 1) three key questions, 2) SCL-dep6, 3) SCL-10, 4) 9 other SCL questions and 5) WHO-5 in a clinical study among adolescents. The Composite International Diagnostic Interview (CIDI) is to be used as the gold standard interview. The project is a GP multicenter study to be conducted in both Norway and Denmark. Inclusion criteria are age (14-16) and fluency in the Norwegian and Danish language. A number of GPs will be recruited from both countries and at least 162 adolescents will be enrolled in the study from the patient lists of the GPs in each country, giving a total of at least 323 adolescent participants. Discussion: The proportion of adolescents suffering from depressive disorders also seems to be increasing worldwide. Early interventions are known to reduce this illness. The earlier depression can be identified in adolescents, the greater the advantage. Therefore, we hope to find a suitable questionnaire that could be recommended for GPs

**Khan N, Bower P, Rogers A. Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience. *British Journal of Psychiatry* 2007    191    206-11. DOI: 10.1192/bjp.bp.106.032011**

Background: There is a gap between the supply of trained cognitive-behavioural therapists to treat depression and demand for care in the community. There is interest in the potential of self-help interventions, which require less input from a therapist. However, the design of effective self-help interventions is complex. Qualitative research can help to explore some of this complexity. AIMS: The study aimed to identify qualitative studies of patient experience of depression management in primary care, synthesise these studies to develop an explanatory framework, and then apply this framework to the development of a guided self-help intervention for depression. Method: A meta-synthesis was conducted of published qualitative research. Results: The synthesis revealed a number of themes, including the nature of personal experience in depression; help-seeking in primary care; control and helplessness in engagement with treatment; stigma associated with treatment; and patients' understandings of self-help interventions. Conclusions: This meta-synthesis of qualitative studies provided a useful explanatory framework for the development of effective and acceptable guided self-help interventions for depression

**Kiviruusu O, Huurre T, Aro H. Psychosocial resources and depression among chronically ill young adults: are males more vulnerable? *Social Science and Medicine* 2007 65 (2) 173-86 DOI: 10.1016/j.socscimed.2007.02.030**

This population-based study examined the association between chronic illness and depression and the role of psychosocial resources (coping styles, locus of control (LOC) and social support) in this association, among young Finnish adults aged 32. Gender differences in these phenomena were also investigated. The study was based on questionnaire data from a Finnish cohort study. Participants with self-reported chronic illness (e.g. diabetes, asthma, migraine) were grouped together (n=257) and compared to healthy controls (n=664). The results showed that the chronically ill males were more depressed than healthy control males. They also used more emotion-focused coping, had a more external LOC and were less often married or cohabiting than healthy males. The association between chronic illness and depression among males attenuated when the effects of emotion-focused coping disposition and LOC were taken into account, indicating a possible mediating role for these resources. Among females no differences were found in depression or psychosocial resources between the chronically ill and healthy control groups. Psychosocial resources, especially LOC, explained the gender difference in the association between chronic illness and depression. Only a few buffering effects of psychosocial resources emerged: an active problem-solving coping disposition among the chronically ill males and perceived social support among the chronically ill females seemed to act as buffers against depression. The results indicated a significant gender disparity in the association between chronic illness and depression among young adults and emphasised the role of psychosocial resources in this context. With regard to prevention we suggest that, chronically ill young adult males should be recognised as a risk group for depression that would probably benefit from guidance in learning more active coping skills and maintaining a sense of personal control in facing chronic physical illness.

**Kyngas H A. Predictors of good adherence to adolescents with diabetes (insulin-dependent diabetes mellitus). *Chronic Illness* 2007;3:20-8 DOI: 10.1177/1742395307079191**

Objectives: The purpose of this study was to identify the factors that predict good adherence to health regimens by adolescents with diabetes (insulin-dependent diabetes mellitus). Methods: Altogether, 300 individuals aged 13-17 years were randomly selected from the Finnish Social Insurance Institution's register. Ninety-seven per cent (N=289) of the selected adolescents returned the questionnaire. The data were analysed using the SPSS (Statistical Package for Social Sciences) for Windows software package. Logistic regression was used to find the factors that predict good adherence to health regimens. Results: About one-fifth (19%) of the respondents with diabetes felt that they complied fully with the health regimens, while 75% placed themselves in the category of satisfactory adherence, and the remaining 6% reported poor adherence. The most powerful predictor was the threat to mental wellbeing. The likelihood that adolescents who felt the disease to be a threat to their mental wellbeing would comply with health regimens was 7.68-fold as compared to those who did not regard the disease as a threat to their mental wellbeing. The next most powerful predictor was support from physician. The support from nurses, and the motivation, energy and willpower to take care of themselves and the threat to physical wellbeing, also predicted good adherence. The logistic regression model explained 82% of the variance, and the model predicted correctly 88% of the adolescents with good adherence. Discussion: This paper shows that adolescents with diabetes show quite good adherence. It also indicates the factors that predict good adherence to health regimens. To improve adherence, these factors should be given special attention in the care of adolescents.

**Loh A et al The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. *Patient Education and Counseling* 2007 67 (3) 324-332 DOI: 10.1016/j.pec.2007.03.023**

Objective: Patient-centred depression care approaches should better address barriers of insufficient patient information and involvement in the treatment decision process. Additional research is needed to test the effect of increased patient participation on outcomes. The aim of this study was to assess, if patient participation in decision-making via a shared decision-making intervention leads to improved treatment adherence, satisfaction, and clinical outcome without increasing consultation time. Methods: Cluster-randomized controlled intervention study based on physician training and patient-centered decision aid compared to usual care in primary care settings in Südbaden region of Germany. Twenty-three primary care physicians treating 405 patients with newly diagnosed depression were enrolled. Patient involvement was measured with the patient perceived involvement in care scale (PICS) and a patient participation scale (MSH-scale). Patient satisfaction was measured by the CSQ-8 questionnaire. Treatment adherence was evaluated by patient and provider self-report. Depression severity and remission outcomes were assessed with the Brief PHQ-D. Results: Physician facilitation of patient participation improved significantly and to a greater extent in the intervention compared to the control group. There was no intervention effect for depression severity reduction.

Doctor facilitation of patient participation, patient-rated involvement, and physician assessment of adherence improved only in the intervention group. Patient satisfaction at post-intervention was higher in the intervention group compared to the control group. The consultation time did not differ between groups. Conclusion: A shared decision-making intervention was better than usual care for improving patient participation in treatment decision-making, and patient satisfaction without increasing consultation time. Additional research is needed to model causal linkages in the decision-making process in regard to outcomes. Practice implicationS: The study results encourage the implementation of patient participation in primary care of depression.

**Rafanelli C, Fava GA, Sonino N Sequential treatment of depression in primary care *International Journal of Clinical Practice* 2007 61 (10) 1719-1729 DOI: 10.1111/j.1742-1241.2007.01342.x**

Background: In the past decade, in clinical psychiatry several investigations suggested the usefulness of a sequential way of integrating pharmacotherapy and psychotherapy in mood disorders. The aim of this paper was to illustrate the practical implications of sequential treatment strategy for depression in primary care, with particular reference to the increasingly common problem of recurrent depression. Methods: The Authors tried to integrate the evidence which derives from meta-analyses and comprehensive general reviews with the insights which derive from controlled studies concerned with specific populations. Conclusions: The sequential treatment of mood disorders is an intensive, two-stage approach, which derives from the awareness that one course of treatment with a specific tool (whether pharmacotherapy or psychotherapy) is unlikely to entail solution to the affective disturbances of patients, both in research and in clinical practice settings. The aim of the sequential approach is to add therapeutic ingredients as long as they are needed. In this sense, it introduces a conceptual shift in clinical practice.

**Reilly S Care management in mental health services in England and Northern Ireland: do integrated organizations promote integrated practice? *Journal of Health Services Research and Policy* October 2007 12 (4) 236-241 DOI: 10.1258/135581907782101633**

Objective: To explore whether integrated structures are associated with more integrated and differentiated forms of care management in mental health services. Method: Cross-sectional postal survey of care management arrangements in local authority social services departments in England (n = 101) and health and social services Trusts in Northern Ireland (NI) (n = 11). Results: Some, but not all, indicators showed more evidence of integrated practice in NI mental health and social services. This included: greater involvement of health care staff in care management; greater multidisciplinary working and a more integrated approach to assessment and care planning processes; a more differentiated approach to care management, including greater targeting of care management resources; a closer link between care management and specialist provision; and overall more integrated practice. Conclusions: This study concurs with previous research showing that structurally integrated health and social services in NI are more conducive towards, although insufficient to secure, integrated working. As the nature,

type of services and ways of working appear to be broadly similar in England and NI, this may imply that greater structural integration per se may not lead to better service outcomes.

**Richards DA, et al. Collaborative care for depression in UK primary care: a randomized controlled trial. *Psychological Medicine* 6 September 2007 1-9. Epub ahead of publication DOI: 10.1017/S0033291707001365**

Background: Collaborative care is an effective intervention for depression which includes both organizational and patient-level intervention components. The effect in the UK is unknown, as is whether cluster- or patient-randomization would be the most appropriate design for a Phase III clinical trial .Method We undertook a Phase II patient-level randomized controlled trial in primary care, nested within a cluster-randomized trial. Depressed participants were randomized to 'collaborative care' - case manager-coordinated medication support and brief psychological treatment, enhanced specialist and GP communication - or a usual care control. The primary outcome was symptoms of depression (PHQ-9). Results: We recruited 114 participants, 41 to the intervention group, 38 to the patient randomized control group and 35 to the cluster-randomized control group. For the intervention compared to the cluster control the PHQ-9 effect size was 0.63 (95% CI 0.18-1.07). There was evidence of substantial contamination between intervention and patient-randomized control participants with less difference between the intervention group and patient-randomized control group (-2.99, 95% CI -7.56 to 1.58, p=0.186) than between the intervention and cluster-randomized control group (-4.64, 95% CI -7.93 to -1.35, p=0.008). The intra-class correlation coefficient for our primary outcome was 0.06 (95% CI 0.00-0.32). Conclusions: Collaborative care is a potentially powerful organizational intervention for improving depression treatment in UK primary care, the effect of which is probably partly mediated through the organizational aspects of the intervention. A large Phase III cluster-randomized trial is required to provide the most methodologically accurate test of these initial encouraging findings

**Watts BV et al Outcomes of a quality improvement project integrating mental health into primary care. *Quality and Safety in Health Care* 16 (5) 378-381 DOI: 10.1136/qshc.2007.022418**

Objective: Depression is commonly seen, but infrequently adequately treated, in primary care clinics. Improving access to depression care in primary care clinics has improved outcomes in clinical trials; however, these interventions are largely unstudied in clinical settings. This study examined the effectiveness of a quality improvement project improving access to mental healthcare in a large primary care clinic. Methods: A before-after study evaluating the efficacy of the integration of a primary mental healthcare (PMHC) clinic into a large primary care clinic at the White River Junction, Vermont Veterans Affairs Medical Center (VAMC). In the before period (2003), a traditional referral and schedule model was used to access mental healthcare services. Patients who had screened positive for depression using a depression screen for 6 months after entry into either model were retrospectively followed. VA clinics without a PMHC were used

as a control. The proportion of patients who received any depression treatment and guideline-adhering depression treatment in each model was compared, as well as the volume of patients seen in mental health clinics and the wait time to be seen by mental health personnel. Results: 383 and 287 patients screened positive for depression at VAMC and the community-based outreach clinic, respectively. Demographics of the before and after cohorts did not differ. The PMHC model was associated with a greater proportion of patients who had screened positive for depression obtaining some depression treatment (52.3% vs 37.8%;  $p < 0.001$ ), an increase in guideline-adherent depression treatment for depression (11% vs 1%;  $p < 0.001$ ). Conclusions: Implementation of the PMHC model was associated with more rapid and improved treatment for depression in the population of patients who screened positive for depression. More widespread implementation of this model should be investigated.

**Weich S et al Treatment of depression in primary care: Socio-economic status, clinical need and receipt of treatment *British Journal of Psychiatry* 191 (2) 164-169**

Background: Depression is prevalent, costly and often undertreated. Aims: To test the hypothesis that people with low socio-economic status are least likely to receive and adhere to evidence-based treatments for depression, after controlling for clinical need. Method: Individuals with an ICD-10 depressive episode in the past 12 months ( $n = 866$ ) were recruited from 7271 attendees in 36 general practices in England and Wales. Depressive episodes were identified using the 12-month Composite International Diagnostic Interview. Treatment receipt and adherence were assessed by structured interview, and rated using evidence-based criteria. Results: We identified 332 individuals (38.3%) who received and adhered to evidence-based treatment. There were few socio-economic differences in treatment allocation. Although those without educational qualifications were least likely to receive psychological treatments (OR = 0.55, 95% CI 0.34-0.89,  $P = 0.02$ ), this association was not statistically significant after adjusting for depression severity. Conclusions: We found no evidence of inverse care in the treatment of moderate and severe depression in primary care in England and Wales.

**Williams JBW et al, Primary care patients in psychiatric clinical trials: a pilot study using videoconferencing *Annals of General Psychiatry* 4/10/2007 6:24 DOI: 10.1186/1744-859X-6-24**

Background While primary care physicians play a pivotal role in the treatment of depression, collaboration between primary care and psychiatry in clinical research has been limited. Primary care settings provide unique opportunities to improve the methodology of psychiatric clinical trials, by providing more generalizable and less treatment-resistant patients. We examined the feasibility of identifying, recruiting, screening and assessing primary care patients for psychiatric clinical trials using high-quality videoconferencing in a mock clinical trial. Methods 1,329 patients at two

primary care clinics completed a self-report questionnaire. Those screening positive for major depression, panic, or generalized anxiety were given a diagnostic interview via videoconference. Those eligible were provided treatment as usual by their primary care physician, and had 6 weekly assessments by the off-site clinician via videoconferencing. Results 45 patients were enrolled over 22 weeks, with 36 (80%) completing the six-week study with no more than 2 missed appointments. All diagnostic groups improved significantly; 94% reported they would participate again, 87% would recommend participation to others, 96% felt comfortable communicating via videoconference, and 94% were able to satisfactorily communicate their feelings via video. Conclusions Results showed that primary care patients will enroll, participate in and complete psychiatric research protocols using remote interviews conducted via videoconference.

## **NEED AND DEMAND FOR CARE**

**Bayliss EA et al Supporting self-management for patients with complex medical needs: recommendations of a working group *Chronic Illness* June 2007 3 (2) 167-175 DOI: 10.1177/1742395307081501**

Increasing numbers of persons live with complex chronic medical needs and are at risk for poor health outcomes. These patients require unique self-management support, as they must manage many, often interacting, tasks. As part of a conference on Managing Complexity in Chronic Care sponsored by the Department of Veterans Affairs, a working group was convened to consider self-management issues specific to complex chronic care. In this paper, we assess gaps in current knowledge on self-management support relevant to this population, report on the recommendations of our working group, and discuss directions for future study. We conclude that this population requires specialized, multidimensional self-management support to achieve a range of patient-centred goals. New technologies and models of care delivery may provide opportunities to develop this support. Validation and quantification of these processes will require the development of performance measures that reflect the needs of this population, and research to prove effectiveness.

**Bryant LD et al The lure of “patient choice” *British Journal of General Practice* October 2007 57 (543) 822-826**

As primary care practitioners are the health professionals closest to patients' everyday lives, they are most likely to experience the impact of policies that support the patient choice agenda. The government's approach to increasing patient choice has been subject to criticism by those sceptical of its politics and by those concerned with its influence on

health providers and some patient groups. A perspective missing from the debate is one informed by research on the psychology of choice. Some psychologists have argued that a seemingly inbuilt preference for choice can adversely affect the decision-making process and that presenting healthcare decisions as choices may result in less reasoned decision making. It is important that GPs encourage patients to make reasoned healthcare decisions that are informed by an evaluation of the options rather than by a simple preference for choice. Patients are likely to be less satisfied with, and experience more regret about, choices made without reasoning.

**Greaves CJ, Campbell JL Supporting self-care in general practice *British Journal of General Practice* October 2007 57 (543) 814-821**

There is both a clear need and a political will to improve self-care in long-term conditions: demand for self-care support interventions is rising. This article discusses current approaches to supporting self-care in primary care, evidence in favour of self-care support, and issues for GPs to consider in planning self-care support systems. In planning care pathways, important choices need to be made about whether to use individual or group-based approaches and what intensity of intervention is appropriate to match patient needs. Investment may also be needed in both health professional competences and practice systems to optimise their ability to support patient self-care. Self-care support is a key approach for the future of UK health care. Practices that are well trained and well organised to support self-care will respond better to the complex challenges of achieving improvements in the outcomes of long-term conditions.

## **ORGANIZATIONS**

**Jones N, Thomas P Inter-organizational collaboration and partnerships in health and social care *Public Policy and Administration* 22 (3) 289-303 DOI: 10.1177/0952076707078761**

Inter-agency collaboration in the public sector remains chronically difficult, especially in the field of health and social care services; yet governments understandably remain enthusiastic about it. This article critically examines the potential of networked collaboration, which involves IT to facilitate inter-organizational collaboration, with particular reference to health and social care services. Networked collaboration can be implemented by the use of social software such as blogs, wikis and online discussion groups, which have been designed for the purpose of communication and collaboration. As a result of technological innovations it is now possible to engage in synchronous (real time) interactions that are not limited by location. The role of virtual collaborative conference facilities offers open access to shared information in health and social services, a place for collaborative activities and discussion tools. What current

developments in social software can do is to offer ways of facilitating and enabling the necessary partnerships in health and social care services to move forward by reducing some of the main barriers to communications between managers and professionals across organizational boundaries.

**Paton C Visible hand or invisible fist?: the new market and choice in the English NHS** *Health Economics Policy and Law* 2007 2 (3) 317-325 DOI: 10.1017/S174413310700415X

As England (unlike the rest of the UK) retreads the market route in health policy, it is worth asking two questions. Firstly, is the government right that the 'new market' (as it refuses to call it, except in private seminars) is fundamentally different from the 1990s' internal market which New Labour allegedly abolished in 1997? Secondly, given that the new market is clearly not characterized by the invisible hand, should we characterize it as steered 'economically' by a visible (facilitating) hand, on the one hand, or managed 'politically' by a fist which would like to remain invisible in order to maintain its power? This article goes on to examine choice in the new NHS with reference to Hirschman (1970), arguing that genuflections to the latter by pro-choice advocates such as Le Grand (2003) are just that - genuflections. Hirschman is used as a taxi by which to reach a desired destination rather than a stimulus to critical reflection, Hirschman-style, upon how 'exit', 'voice', and particular combinations of 'exit' and 'voice' may produce perverse outcomes.

**Warwick P, The rise and fall of the patient forum.** *British Journal of Healthcare Management* 2007 13 (7) 250-4.

The circular A Stronger Local Voice (Department of Health 2006) published in July announced that Patient Forums in England will be abolished to be replaced by local authority run Local Involvement Networks (LINKs). What went wrong with Forums? What was wrong with Community Health Councils before them? Will LINKs be judged to be more successful? Is there anything to be gained from another major reorganisation of public involvement arrangements?

## **PATIENT AND PUBLIC INVOLVEMENT**

**Anton S, et al. Involving the public in NHS service planning.** *Journal of Health Organization and Management* 2007; 21 (4/5) :470-83. DOI: 10.1108/14777260710778989

Purpose - The purpose of this paper is to report the findings of a study that examined the development of an assessment framework for public involvement. Design/methodology/approach - The paper has adopted a multi-method approach that includes: a focused review of literature relating to tools that might be used to provide valid and reliable assessments of public involvement; key informant interviews with people with experience from various perspectives of efforts to involve the public in the planning and development of health services; and a detailed study of a specific public involvement initiative involving a range of "stakeholder" interviews. Findings - The paper finds that there are uncertainty and a lack of consensus about how assessment of public involvement should be undertaken. The findings emphasise the need to recognise the diverse nature of public involvement, which may require assessment to be employed flexibly at each individual NHS Board level. Research limitations/implications - The paper is a small-scale study, in which it was only possible to probe a limited number of stakeholders' views due to practical and time restrictions. Originality/value - The paper adds value to the discussions taking place at Scottish Government level as to the best approach in assessing public involvement in health service decision making.

**Baker A. Patient involvement in a professional body: reflections and commentary.**  
*Journal of Health Organization and Management* 2007; 21 (4/5) 460-9. DOI:  
10.1108/14777260710778970

Purpose – The purpose of this paper is to consider the issues which emerge when an autonomous, professional, member-led organisation attempts to demonstrate its accountability to patients through lay involvement in its standard-setting processes. Design/methodology/approach – The paper reports a project, which is still in progress and could be described as action research. Data were collected through participant observation in a series of discussions and working groups. A limited literature search was carried out at the start of the initiative but found little which relates to lay involvement in professional bodies. Findings – The paper finds that patient involvement in a professional body is unlikely by itself to be a useful mechanism for delivering greater professional accountability. Research limitations/implications – The paper is a single case study and can only suggest hypotheses for further research. Practical implications – The paper shows that professional bodies of various types are increasingly being asked to demonstrate public involvement in their decision making. It is important to identify the most effective mechanisms for this and the limitations inherent in the structures of organisations, which are accountable primarily to their members. Originality/value – The paper shows that individual doctors are held to account through a number of mechanisms, but little attention has been given to how medical professional bodies can be made more accountable for the collective power they hold. Patient involvement is interpreted within a consumerist model, which focuses on the doctor-patient relationship and ignores the considerable strategic influence which medical royal colleges exercise within the health service.

**Cox K et al Patients' involvement in decisions about medicines: GPs' perceptions of their preferences** *British Journal of General Practice* October 2007 57 (543) 777-784

**Background:** Patients vary in their desire to be involved in decisions about their care. **Aim:** To assess the accuracy and impact of GPs' perceptions of their patients' desire for involvement. **Design of study:** Consultation-based study. **Setting:** Five primary care centres in south London. **Method:** Consecutive patients completed decision-making preference questionnaires before and after consultation. Eighteen GPs completed a questionnaire at the beginning of the study and reported their perceptions of patients' preferences after each consultation. Patients' satisfaction was assessed using the Medical Interview Satisfaction Scale. Analyses were conducted in 190 patient-GP pairs that identified the same medicine decision about the same main health problem. **Results:** A total of 479 patients participated (75.7% of those approached). Thirty-nine per cent of these patients wanted their GPs to share the decision, 45% wanted the GP to be the main (28%) or only (17%) decision maker regarding their care, and 16% wanted to be the main (14%) or only (2%) decision maker themselves. GPs accurately assessed patients' preferences in 32% of the consultations studied, overestimated patients' preferences for involvement in 45%, and underestimated them in 23% of consultations studied. Factors protective against GPs underestimating patients' preferences were: patients preferring the GP to make the decision (odds ratio [OR] 0.2 per point on the five-point scale; 95% confidence interval [CI] = 0.1 to 0.4), and the patient having discussed their main health problem before (OR 0.3; 95% CI = 0.1 to 0.9). Patients' educational attainment was independently associated with GPs underestimation of preferences. **Conclusion:** GPs' perceptions of their patients' desire to be involved in decisions about medicines are inaccurate in most cases. Doctors are more likely to underestimate patients' preferred level of involvement when patients have not consulted about their condition before.

**Davis RE, et al Patient involvement in patient safety: what factors influence patient participation and engagement? *Health Expectations*. 2007 10 (3) 259-67. DOI: 10.1111/j.1369-7625.2007.00450.x**

**Background:** Patients can play an important role in improving patient safety by becoming actively involved in their health care. However, there is a paucity of empirical data on the extent to which patients take on such a role. In order to encourage patient participation in patient safety we first need to assess the full range of factors that may be implicated in such involvement. **Objective:** To delineate factors that could affect the participation of the patient in quality and safety issues in their health care. **Method:** Literature review of patient involvement in health care, drawing from direct evidence (specifically from the safety context) and indirect evidence (extrapolated from treatment decision-making research and the wider patient involvement in health care literature); synthesis and conceptual framework developed, illustrating the known and putative factors that could affect the participation of the patient in safety issues in their health care. **Main results:** Five categories of factors emerged that could affect patient involvement in safety: patient-related (e.g. patients' demographic characteristics), illness-related (e.g. illness severity), health-care professional-related (e.g. health care professionals' knowledge and beliefs), health care setting-related (e.g. primary or secondary care), and task-related (e.g. whether the required patient safety behaviour challenges clinicians' clinical abilities). **Conclusion:** The potential for engaging patients in patient safety is considerable but

further research is needed to examine the influences on patient involvement, the limits and the possible dangers. Patients can act as 'safety buffers' during their care but the responsibility for their safety must remain with the health care professionals

**Deber RB et al. Do people want to be autonomous patients? Preferred roles in treatment decision-making in several patient populations *Health Expectations*. 2007 10 (3) 248-58. DOI: 10.1111/j.1369-7625.2007.00441.x**

Background: What role do people want to play in treatment decision-making (DM)? Objective: Examine the role patients indicate they would prefer in making treatment decisions across multiple clinical settings in Ontario, Canada. Design: Secondary analysis of a series of survey/interview-based studies measuring preferred role, conducted in 12 different populations. Setting and participants: Respondents were outpatients, largely but not entirely attending outpatient clinics in large teaching hospitals in urban settings in the Province of Ontario, Canada. The subgroups and sample sizes were: breast cancer (202), prostate disease (202), fractures (202), continence (46), orthopaedic (111), rheumatology (56), multiple sclerosis (22), HIV/AIDS (431), infertility (454), benign prostatic hyperplasia (678) and cardiac disease (300), plus 50 healthy nursing students (for scale validation). Measurements: All studies categorized preferred role using the Problem-Solving Decision-Making (PSDM) scale with one or both of the Current Health condition and Chest Pain vignettes. Results: Few respondents preferred an autonomous role (1.2% for the current health condition vignette and 0.7% for the chest pain vignette); most preferred shared DM (77.8% current health condition; 65.1% chest pain) or a passive role (20.3% current health condition; 34.1% chest pain). Familiarity with a clinical condition increases desire for a shared (as opposed to passive) role. Preferences for passive vs. shared roles varied across settings; older and less educated individuals were most likely to prefer passive roles. Conclusions: Despite consumerist rhetoric among some bioethicists, very few respondents wish an autonomous role. Most wish to share DM with their providers

**Garfield S et al Can patients' preferences for involvement in decision-making regarding the use of medicines be predicted? *Patient Education and Counseling* 2007 66 (3) 361-367 DOI: 10.1016/j.pec.2007.01.012**

Objective: The current study aimed to develop a model of patients' preferences for involvement in decision-making concerning the use of medicines for chronic conditions in the UK and test it in a large representative sample of patients with one of two clinical conditions. Methods: Following a structured literature review, an instrument was developed which measured the variables that had been identified as predictors of patients' preferences for involvement in decision making in previous research. Five hundred and sixteen patients with rheumatoid arthritis or type 2 diabetes were recruited from outpatient and primary care clinics and asked to complete the instrument. Results: Multivariate analysis revealed that age, social class and clinical condition were associated with preferences for involvement in decision-making concerning the use of medicines for chronic illness but gender, ethnic group, concerns about medicines, beliefs about

necessity of medicines, health status, quality of life and time since diagnosis were not. In total, the fitted model explained only 14% of the variance. Conclusion: This study has demonstrated that current research does not provide a basis for predicting patients' preferences for involvement in decision-making. Practice implications: Building concordant relationships may depend on practitioners developing strategies to establish individuals' preferences for involvement in decision-making as part of the ongoing prescriber-patient relationship.

**Jaakkola E. Physicians' views on the influence of patient participation on treatment decisions - an explorative study. *Health Services Management Research* 2007 20 (3) 174-82. DOI: 10.1258/095148407781395937**

While patient participation in treatment decisions is increasingly advocated in medical literature, patient demand has been considered to cause unnecessary prescribing. Using the concept of customer participation as discussed in services marketing and management literature as a theoretical base, the paper analyses the influence of patient participation on the medical service process and treatment decision-making. A qualitative, explorative study was conducted to investigate American and British physicians' views on patient participation in the treatment of osteoporosis and schizophrenia. It became evident that in the cases of both osteoporosis and schizophrenia, patients influence prescribing decisions despite the significant difference in their willingness and ability to participate. The manifestations of patient participation were divided into three groups: (1) resources, such as the patient's condition and information about it, and his/her preconceived notions and preferences, (2) actions, such as preparing for the service, negotiating decisions and implementing the treatment, and (3) the patient's role expectations and inclination to participate. The influence of such manifestations on prescribing decision-making is discussed in detail, and differences between the studied illnesses are explained. Implications to health-care managers and practitioners are discussed

**Lindenmeyer A, et al. Assessment of the benefits of user involvement in health research from the Warwick Diabetes Care Research User Group: a qualitative case study. *Health Expectations* 2007 10 268-77. DOI: 10.1111/j.1369-7625.2007.00451.x**

Objective: To assess the benefits of involving health-care users in diabetes research. Design and participants: For this qualitative case study, semi-structured interviews were conducted with researchers who had worked extensively with the group. During regular meetings of the Research User Group, members discussed their views of the group's effectiveness as part of the meeting's agenda. Interviews and discussions were transcribed, coded using N-Vivo software and analysed using constant comparative methods. Results: Involvement of users in research was generally seen as contributing to effective and meaningful research. However, the group should not be considered to be representative of the patient population or participants of future trials. An important contributor to the group's success was its longstanding nature, enabling users to gain

more insight into research and form constructive working relationships with researchers. The user-led nature of the group asserted itself, especially, in the language used during group meetings. A partial shift of power from researchers to users was generally acknowledged. Users' main contribution was their practical expertise in living with diabetes, but their involvement also helped researchers to remain connected to the 'real world' in which research would be applied. While the group's work fulfilled established principles of consumer involvement in research, important contributions relying on personal interaction between users and researchers were hard to evaluate by process measures alone. Conclusions: We demonstrated the feasibility, acceptability and effectiveness of this longstanding, experienced, lay-led research advisory group. Its impact on research stems from the continuing interaction between researchers and users, and the general ethos of learning from each other in an on-going process. Both process measures and qualitative interviews with stakeholders are needed to evaluate the contributions of service users to health research

**Redman B K. Accountability for patient self-management of chronic conditions: ethical analysis and a proposal. *Chronic Illness* 2007;3:88. DOI: 10.1177/1742395307079196**

Patient self-management (PSM) of varying portions of therapy for chronic illness is expanding. However, several current conditions of practice are ethically problematic. Standards remain process-oriented, and accountability for patient outcomes and quality of practice of both patient and provider is diffuse. PSM carries important benefits but largely unmonitored potential harms. Also, access to preparation for safe PSM appears to be skewed in favour of high socio-economic classes. This condition persists even though available evidence supports the conclusion that less advantaged patients with poor disease outcomes can be taught to self-manage, albeit they require more intensive and prolonged interventions. Routine clinical use of well-validated measurement instruments could serve to develop evidence-based standards of PSM, quality improvement and effective public policy. Development of a standard dataset would facilitate description of the effectiveness of existing programmes and comparison across programmes. Such reform will require investment in the development of instruments that measure patient ability to make sound clinical judgements and sustain PSM over changed disease and social conditions. It will take advantage of modern psychometric theory, which is increasingly necessary for building the empirical base for evidence-based healthcare.

**Rees C, Knight LV, Wilkinson CE. Doctors being up there and we being down here: a metaphorical analysis of talk about student/doctor-patient relationships. *Social Science and Medicine* 2007 65 (4) 725-37 DOI: 10.1016/j.socscimed.2007.03.044**

This paper describes the metaphorical conceptualisations of student/doctor-patient relationships, as articulated by multiple stakeholders in healthcare. Eight focus group discussions with 19 patients, 13 medical students and 15 medical educators (comprising doctors, other healthcare professionals and non-clinical academics) were conducted in England and we subjected our transcribed and audiotaped data to a secondary level of

data analysis i.e. systematic metaphor analysis. The analysis revealed six over-arching metaphors associated with the target domain of student/doctor-patient relationships i.e. STUDENT/DOCTOR-PATIENT RELATIONSHIPS AS WAR, HIERARCHY, DOCTOR-CENTREDNESS, MARKET, MACHINE and THEATRE. All of the metaphors (except theatre) emphasised the oppositional quality of student/doctor-patient relationships. Three of the source domains emerging from our empirical data (i.e. hierarchy, doctor-centredness, and market) relate to metaphors already employed in the non-empirical literature to discuss doctor-patient relationships (e.g. paternalism, patient-centredness, and consumerism). The three remaining source domains (i.e. war, machine and theatre) were novel in their conceptualisation of student/doctor-patient relationships, albeit that they have been reported in previous empirical literature to describe other target domains. In this paper, we discuss each of these metaphors and their associated entailments, including those found in our data and those absent from our data. We also differentiate between the unconscious use of metaphorical linguistic expressions by our participants and those serving a rhetorical function. Although analysing metaphoric talk is not without its difficulties, the construction of metaphoric models can help social researchers better understand how individuals conceptualise and construct student/doctor-patient relationships.

## PRIMARY/SECONDARY CARE INTERFACE

**Calnan M, et al** A qualitative study exploring variations in GPs' out-of-hours referrals to hospital. *British Journal of General Practice* 2007 57 (542) 706-13.

Background: There is evidence of significant variations in hospital referral rates for GPs working in out-of-hours care. Aims: To explain why there are marked variations in hospital referral rates for GPs working in out-of-hours care. Design of study: In depth, face-to-face interviews with a purposive sample of GPs with different out-of-hours referral rates. Setting: Bristol, UK. Method: GPs were selected according to their rate of out-of-hours hospital referral. They were classified as high, medium, or low referrers. Five interviews were carried out with GPs from each of the three categories. Results: High referring GPs are typically cautious and believe it is better to admit if in doubt. They express anxiety about the consequences of a decision not to admit, both for the patient and for themselves. They hold negative attitudes towards alternatives to hospital admission. Low referrers were more confident about their decisions and less often worried afterwards. Low referrers were positive about alternatives to hospital admission and described themselves as able to resist pressures from family or carers to have someone admitted. Low referrers also see hospitals as places to be avoided and viewed their goal as preventing an admission. Conclusion: Educational programmes need to be developed to improve GPs' judgements of their competences and to build appropriate levels of confidence

**Garasen H, Johnsen R. The quality of communication about older patients between hospital physicians and general practitioners: a panel study assessment. *BMC Health Services Research* 2007 7:1 24/8/2007 DOI: 10.1186/1472-6963-7-133**

Background: Optimal care of patients is dependent on good professional interaction between general practitioners and general hospital physicians. In Norway this is mainly based upon referral and discharge letters. The main objectives of this study were to assess the quality of the written communication between physicians and to estimate the number of patients that could have been treated at primary care level instead of at a general hospital. MethodS: This study comprised referral and discharge letters for 100 patients above 75 years of age admitted to orthopaedic, pulmonary and cardiological departments at the city general hospital in Trondheim, Norway. The assessments were done using a Delphi technique with two expert panels, each with one general hospital specialist, one general practitioner and one public health nurse using a standardised evaluation protocol with a visual analogue scale (VAS). The panels assessed the quality of the description of the patient's actual medical condition, former medical history, signs, medication, Activity of Daily Living (ADL), social network, need of home care and the benefit of general hospital care. ResultS: While information in the referral letters on actual medical situation, medical history, symptoms, signs and medications was assessed to be of high quality in 84 %, 39 %, 56 %, 56 % and 39 %, respectively, the corresponding information assessed to be of high quality in discharge letters was for actual medical situation 96 %, medical history 92 %, symptoms 60 %, signs 55 % and medications 82 %. Only half of the discharge letters had satisfactory information on ADL. Some two-thirds of the patients were assessed to have had large health benefits from the general hospital care in question. One of six patients could have been treated without a general hospital admission. The specialists assessed that 77 % of the patients had had a large benefit from the general hospital care; however, the general practitioners assessment was only 59 %. One of four of the discharge letters did not describe who was responsible for follow-up care. Conclusions: In this study both referral and discharge letters were missing vital medical information, and referral letters to such an extent that it might represent a health hazard for older patients. There is also low consensus between health professionals at primary and secondary level of what is high benefit of care for older patients at a general hospital

**Halter M et al A patient survey of out-of-hours care provided by Emergency Care Practitioners. *BMC Emergency Medicine* 15<sup>th</sup> June 2007 7:4. DOI: 10.1186/1471-227X-7-4**

Background: Emergency Care Practitioners (ECPs) have recently been deployed to provide out-of-hours primary care home visits - a practice development that has been supported by policy makers. The aim of the study was to evaluate the care provided to patients receiving out-of-hours home visits from ECPs in London from the patients' perspective and to assess their wellbeing following the visit. Methods: A bespoke telephone-administered questionnaire was designed to survey all patients who had received out-of-hours care in Bromley Primary Care Trust from ECPs during a ten week

period in 2005 (n = 174). Results: Sixty three patients (36.2%) were excluded because: no telephone number was available; they had a diagnosis of dementia; or had not received a study information sheet. The remainder (n = 111) were contacted 3-5 days after the home visit, and 81 of these (73.0%) completed the survey. Of those respondents treated at home who gave unequivocal answers (n = 60), all but one (8.3%) reported that they felt that their treatment had been 'right' and/or had followed any advice given. However, overall only 86.4% reported that they had been clear about their ECP's assessment, and only 58.0% reported that their health was now 'better'. Those who reported that they were not clear about their assessment were less likely to report that their health was 'better' (p = 0.03) and more likely to have subsequently used hospital-based health services (p = 0.03). Conclusion: Most patients treated at home by ECPs appeared satisfied and compliant with the care provided, according to the measures used in this study. However, it appears that a sizeable minority of patients were unclear about ECP assessments and it remains to be seen whether these patients had pre-existing health complaints which made them less likely to recover and more likely to seek hospital care, or whether the lack of clarity about their assessment undermined their subsequent recovery and necessitated hospital care. Further research is required to establish if the assessments provided by ECPs are less clear than those provided by other practitioners, and whether it is possible to ensure that all such assessments are clear to all patients. Patients hold a mainly positive view of out-of-hours home visit care provided by ECPs, although a lack of clarity about their assessment was evident, with a possible impact on their continuing health

**Lordan G. What determines a patient's treatment? Evidence from out of hours primary care co-op data in the Republic of Ireland. *Health Care Management Science.* 2007 10 (3) 283-92.**

This study explores consistency in healthcare. It investigates whether vulnerable groups in the population receive the most appropriate care. This is achieved by considering the case study of individuals who present to out of hours (OOH) primary care services in the Republic of Ireland with gastroenteritis. Specifically an individual can potentially receive four services; nurse advice, doctor advice, a treatment centre consultation or a home visit. Results show that service choice is influenced by patient, call and seasonal characteristics to varying degrees. Patient symptoms are the primary driver of the type of service the patients receives. Results also indicate that the OOH primary care facilities individual characteristics do not affect service choice. This suggests a degree of consistent care across these organisations. It also provides evidence that service choice is exogenous to the organization

**Moll van Charante EP, van Steenwijk-Opdam PC, Bindels PJ. Out-of-hours demand for GP care and emergency services: patients' choices and referrals by general practitioners and ambulance services. *BMC Family Practice* 2007 8:46. DOI: 10.1186/1471-2296-8-46**

Background: Over the last five years, Dutch provision of out-of-hours primary health care has shifted from practice-based services towards large-scale general practitioner (GP) cooperatives. Only few population-based studies have been performed to assess the

out-of-hours demand for GP and emergency care, including the referral patterns to the Accident and Emergency Department (AED) by GPs and ambulance services. Method: During two four-month periods (five-year interval), a prospective cross-sectional study was performed for a Dutch population of 62,000 people. Data were collected on all patient contacts with one GP cooperative and three AEDs bordering the region. Results: Overall, GPs handled 88% of all out-of-hours contacts (275/1000 inhabitants/year), while the AED dealt with the remaining 12% of contacts (38/1000 inhabitants/year). Within the AED, the self-referrals represented a substantial number of contacts (43%), although within the total out-of-hours demand they only represented 5% of all contacts. Self-referrals were predominantly young adult males presenting with an injury, nineteen percent of whom had a fracture. Compared to self-referrals, patients who were referred by the GP or brought in by the ambulance services were generally older and were more frequently admitted for both injury and non-injury ( $p < 0.01$  for all differences). Conclusions: The GP cooperative deals with the large majority of out-of-hours problems presented. Within the total demand, self-referrals constitute a stable, yet small group of patients, many of whom seem to have made a reasonable choice to attend the AED. The GPs and the ambulance services appear to be effectively selecting the problems that are presented to the AED

## QUALITY OF CARE

**Adam RP** Personal Care' and General Practice medicine in the UK: A qualitative interview study with patients and General Practitioners. *Osteopathic Medicine and Primary Care* 31/8/2007 1(1) 13 DOI: 10.1186/1750-4732-1-13

Background: Recent policy and organisational changes within UK primary care have emphasised graduated access to care, speed of access to the first available general practitioner (GP) and care being provided by a range of healthcare professionals. These trends have been strengthened by the current GP contract and Quality and Outcomes Framework (QOF). Concern has been expressed that the potential for personal care is being diminished and that this will reduce quality standards. This paper presents data from a study that explored with patients and GPs what personal care means and whether it has continuing importance to them. Methods: A semi-structured questionnaire was used to interview participants and Framework Analysis supported analysis of emerging themes. Twenty-nine patients, mainly women with young children, and twenty-three GPs were interviewed from seven practices in Lothian, Scotland, ranged by practice size and relative deprivation score. Results: Personal care was defined mainly, though not exclusively, as care within a continuing relationship in which there is an interpersonal connection and the doctor adopts a particular consultation style. Defined in this way, it was reported to have benefits for both health outcomes and patients' experience of care. In particular, it was thought to be beneficial in attending to the emotions that can be

elicited when seeking and receiving health care and enabling patients to be known by doctors as legitimate seekers of care. Its importance was described as being dependent upon the nature of the health problem and patients' wider familial and social circumstances. It was found to provide support to patients in their parenting and other familial caring roles. Conclusion: Personal care has continuing salience to patients and GPs in UK primary care. Patients equate the experience of care, not just outcomes, with high quality care. As it is mainly conceptualised and experienced as care within the context of a continuing relationship, policies and organisational arrangements that support and incentivise the potential for this must be in place. These preferences are not strongly reflected in the QOF. Specific questions should be addressed by future audit and research on the impact of the contract on these aspects of service.

**Dale J, et al. Telecare motivational interviewing for diabetes patient education and support: a randomised controlled trial based in primary care comparing nurse and peer supporter delivery. *Trials* 2007 8:18 28/6/2007 DOI: 10.1186/1745-6215-8-18**

**Background** There is increasing interest in developing peer-led and 'expert patient'-type interventions, particularly to meet the support and informational needs of those with long term conditions, leading to improved clinical outcomes, and pressure relief on mainstream health services. There is also increasing interest in telephone support, due to its greater accessibility and potential availability than face to face provided support. The evidence base for peer telephone interventions is relatively weak, although such services are widely available as support lines provided by user groups and other charitable services. **Methods/Design** In a 3-arm RCT, participants are allocated to either an intervention group with Telecare service provided by a Diabetes Specialist Nurse (DSN), an intervention group with service provided by a peer supporter (also living with diabetes), or a control group receiving routine care only. All supporters underwent a 2-day training in motivational interviewing, empowerment and active listening skills to provide telephone support over a period of up to 6 months to adults with poorly controlled type 2 diabetes who had been recommended a change in diabetes management (i.e. medication and/or lifestyle changes) by their general practitioner (GP). The primary outcome is self-efficacy; secondary outcomes include HbA1c, total and HDL cholesterol, blood pressure, body mass index, and adherence to treatment. 375 participants (125 in each arm) were sought from GP practices across West Midlands, to detect a difference in self-efficacy scores with an effect size of 0.35, 80% power, and 5% significance level. Adults living with type 2 diabetes, with an HbA1c > 8% and not taking insulin were initially eligible. A protocol change 10 months into the recruitment resulted in a change of eligibility by reducing HbA1c to > 7.4%. Several qualitative studies are being conducted alongside the main RCT to describe patient, telecare supporter and practice nurse experience of the trial. **Discussion and implications of the research** With its focus on self-management and telephone peer support, the intervention being trialled has the potential to support improved self-efficacy and patient experience, improved clinical outcomes and a reduction in diabetes-related complications. **Trial Registration** Current Controlled Trials, ISRCTN63151946

**Garratt AM, Danielsen K, Hunskaar S. Patient satisfaction questionnaires for primary care out-of-hours services: a systematic review. *British Journal of General Practice* 2007 57 (542) :741-7.**

Background: Patient satisfaction questionnaires are increasingly used for assessing quality of care. Aim: To review the evidence for the reliability and validity of patient satisfaction questionnaires for out-of-hours care. Design: Systematic review. SETTING: Primary care out-of-hours services. Method: Searches of CINAHL, EMBASE, MEDLINE((R)) and PsycINFO using terms relevant to the measurement of patient satisfaction and out-of-hours services. Abstracts were reviewed and information relating to questionnaire content, data quality, reliability, and validity were extracted from articles by two independent researchers. Results: Four questionnaires were found, two from the UK - the Patient Satisfaction with Out-of-Hours Care (PSOC) and Short Questionnaire for Out-of-Hours Care (SQOC) - and two from the Netherlands - the van Uden and Moll van Charante questionnaires. Questionnaire content was based on literature reviews and expert opinion; the PSOC and Moll van Charante questionnaires were also developed following interviews or focus groups with patients. Cronbach's alpha values were below 0.7 for some scales within the PSOC and van Uden questionnaires. Test-retest reliability was reported for the PSOC and Moll van Charante questionnaires. Tests of validity were few and did not give explicit consideration to the size of expected associations. Conclusion: Potential users wishing to assess patient satisfaction should carefully consider the content of the questionnaires and its relevance to the application and patient group. The four questionnaires have limitations relating to their development and evaluation. The PSOC and van Uden questionnaires have low levels of reliability for some scales, which should be used with caution in future surveys

**Giesen P, et al Out-of-hours primary care: development of indicators for prescribing and referring. *International Journal of Quality in Health Care* 2007 19 (5) 289-95. DOI: 10.1093/intqhc/mzm027**

Background Dutch general practitioners have reorganized their out-of-hours primary health care to general practice cooperatives. Good insight into the quality of delivered medical care is important to make the accountability of health practitioners and managers transparent to society and to identify and minimize medical errors. Objective: Development of a set of quality indicators for internal quality improvement in out-of-hours primary clinical care. Method: A systematic approach combining the opinion of three different general practitioner expert panels, and an empirical test in daily practice. The indicators were based on clinical, evidence-based, national guidelines. We tested the validity, feasibility, reliability and opportunity for quality improvement. Results: Of the 80 available national clinical guidelines, 29 were approved and selected by the first general practitioner expert panel. Out of these 29 guidelines, 73 indicators concerning prescribing and referring were selected by the second panel. In an empirical test on 36 254 patient contacts, 7344 patient contacts (22.7%) were relevant for the assessment of these 73 indicators. Six indicators were excluded because they scored more than 15%

missing values. In total, 38 indicators were excluded because the opportunity for quality improvement was limited (performance score  $\geq 90\%$ ). In the final meeting, the third general practitioner expert panel excluded five indicators, leading to a final set of 24 indicators. Conclusion: This study shows the importance of subjecting indicators to an empirical test in practice. The national clinical guidelines are only partially applicable in the assessment of out-of-hours primary care. They need to be expanded with topics that are related to general practitioner care in an out-of-hours setting and acute medical problems

**Glynn LG, MacFarlane A, Murphy AW. The complexity of patients' satisfaction with out-of-hours care: a qualitative study. *European Journal of General Practice* 2007; 13 (2) :83-8.**

Background: The national health service in the Republic of Ireland is one of a number of European health services currently undergoing significant reform. Out-of-hours primary care has been at the forefront of this process of change, and although patients appear satisfied, the complexity of their response to changes in out-of-hours care has not been fully explored. Objective: To conduct an analysis of qualitative data collected during a recent study of patients' satisfaction with out-of-hours care in order to explore the full range of patients' views and experiences. Methods: All patients contacting a family-doctor out-of-hours cooperative over a designated 24-day period were forwarded a postal questionnaire. The questionnaire contained a section giving the patient the opportunity to add qualitative comments concerning their experience. The data were analysed according to the principles framework analysis using Nvivo software. Results: Analysis of the data resulted in the development of the following thematic categories: service availability, service accessibility, efficiency, continuity of care and quality of care. There was a range of views, both positive and negative, apparent around these themes, with evidence of patients engaging in careful decisions and "trade-offs" in respect of their options for out-of-hours care. Conclusion: Patients hold a range of views that suggests the complexity around patient satisfaction with out-of-hours care. A qualitative methodological approach can compliment current approaches to the evaluation of patient satisfaction, facilitating the exploration of the full range of patients' views and experiences

**Hankins M, Fraser A, Hodson A, Hooley C, Smith H. Measuring patient satisfaction for the Quality and Outcomes Framework. *British Journal of General Practice* 2007 57 (542) :737-40.**

The general medical services (GMS) contract Quality and Outcomes Framework (QOF) awards up to 70 points for measuring patient satisfaction with either the Improving Practices Questionnaire (IPQ) or the General Practice Assessment Questionnaire (GPAQ). The usefulness of data collected depends crucially on the validity and reliability of the measurement instrument. The literature was reviewed to assess the validity and reliability of these questionnaires. The literature was searched for peer-review publications that assessed the reliability and validity of the IPQ and GPAQ, using online literature databases and hand-searching of references up to June 2006. One paper claimed

to assess the validity and reliability of the IPQ. No paper reported the reliability and validity of the GPAQ, but three papers assessed an earlier version (the GPAS). No published evidence could be found that the IPQ, GPAQ, or GPAS have been validated against external criteria. The GPAS was found to have acceptable reliability and test-retest reliability. Neither of the instruments mandated by the GMS contract has been formally assessed for reliability: their reproducibility remains unknown. The validation of the two questionnaires approved by the QOF to assess patient satisfaction with general practice appears to be suboptimal. It is recommended that future patient experience surveys are piloted for validity and reliability before being implemented widely

**Hann M et al** The association between culture, climate and quality of care in primary health care teams *Family Practice* August 2007 24 (4) 323-329 DOI: 10.1093/fampra/cmm020

Background. Culture and climate represent shared beliefs and values that may influence quality of care in health care teams, and which could be manipulated for quality improvement. However, there is a lack of agreement on the theoretical and empirical relationships between climate and culture, and their relative power as predictors of quality of care. This study sought to examine the association between self-report measures of climate and culture in primary care teams and comprehensive measures of quality of care. Methods. The data were derived from a cross-sectional survey of 492 professionals in 42 general practices in England. Self-report measures of culture (the Competing Values Framework) and climate (the Team Climate Inventory) were used, together with validated measures of quality of care from medical records and self-report. Results. The majority of practices could be characterized as 'clan' culture type. Practices with a dominant clan culture scored higher on climate for participation and teamwork. There were no associations between culture and quality of care, and only limited evidence of associations between climate and quality. Conclusions. The current analysis would not support the hypothesis that culture and climate are important predictors of quality of care in primary care. Although larger studies are required to provide a definitive test, the results may suggest the need for a more complex model of the associations between culture, climate and outcomes, and further research may be required. into the interaction between culture and climate with other determinants of behaviour such as internal and external incentives.

**Hider P** Comparison of services provided by urban commercial, community-governed and traditional primary care practices in New Zealand *Journal of Health Services Research and Policy* October 2007 12 (4) 215-222 DOI: 10.1258/135581907782101525

Objectives: New Zealand has experienced restructuring and reform of primary health care since the 1980s, including the introduction of commercial clinics and increasing numbers of practices run by community-governed organizations. Our aim was to compare commercial, community-governed and traditional practices in five key domains: access; coordination and continuity of care; communication and patient centredness; population health and preventive health; and chronic disease management. Methods: A nationally representative, multistage probability sample of private general practitioners, stratified by

geographical location and practice type, was drawn. Representative samples of urban commercial clinics and of practices governed by community organizations were obtained for the same period (2001-02). All doctors were asked to provide data on themselves, their practice, and to report on a 25% sample of patients in two periods of one week. Results: Among the three practice types, commercial clinics differed most in their organization; they charged higher fees and employed more staff, although their doctors were less experienced. Community-governed practices were visited by more people from lower socioeconomic groups. Commercial clinic patients were more likely to be younger and less likely to have an ongoing relationship with the clinic. They frequently attended for self-limiting problems related to injuries or respiratory problems. Investigations, follow-up and referral rates were similar between the three practice types. Treatment rates were higher at traditional and community-governed general practices. Conclusion: Rather than replicating traditional practices, new practice types provide complementary services and established services in innovative ways. The challenge is to achieve an appropriate mix of diverse providers.

**McKinstry B et al The impact of general practitioner morale on patient satisfaction with care: a cross-sectional study *BMC Family Practice* 8:57 28<sup>th</sup> September 2007 DOI: 10.1186/1471-2296-8-57**

**Background** The association between stress and morale among general practitioners (GP) is well documented. However, the impact of GP stress or low morale on patient care is less clear. GPs in the UK now routinely survey patients about the quality of their care including organizational issues and consultation skills and the General Practice Assessment Questionnaire (GPAQ) is widely used for this purpose. We aimed to see if there was a relationship between doctor morale as measured by a validated instrument, the Morale Assessment in General Practice Index (MAGPI) and scores in the GPAQ. **Methods** All GPs in Lothian, Scotland who were collecting GPAQ data were approached and asked to complete the MAGPI. Using an anonymised linkage system, individual scores on the MAGPI were linked to the doctors' GPAQ scores. Levels of association between the scores were determined by calculating rank correlations at the level of the individual doctor. Hypothesised associations between individual MAGPI and GPAQ items were also assessed. **Results** 276 of 475 GPs who were approached agreed to complete a MAGPI questionnaire and successfully collected anonymous GPAQ data from an average of 49.6 patients. There was no significant correlation between the total MAGPI score and the GPAQ communication or enablement scale. There were weak correlations between "control of work" in the MAGPI scale and GPAQ items on waiting times to see doctors ( $r = 0.24$   $p < 0.01$ ). Doctors who perceived that their patients viewed them negatively also scored lower on individual communication, accessibility and continuity of care GPAQ items. **Conclusion** This study showed no relationship between overall GP morale and patient perception of performance. There was a weak relationship between patients' perceptions of quality and doctors' beliefs about their workload and whether patients value them. Further research is required to elucidate the complex relationship between workload, morale and patients' perception of care.

**Narayanan A, Greco M, What distinguishes general practitioners from consultants, according to colleagues? *Journal of Management and Marketing in Health Care* 2007 1 (1) 80-87**

There is very little understanding of what exactly is being measured when peer review is undertaken and how it should be measured for different target groups. The aim of this study is to determine the basis on which raters distinguish between two sets of colleagues: GPs and consultants. From March to July 2005 a study was run to test a newly created peer assessment tool for doctors in primary and secondary care settings. A total of 33 doctors took part - 14 GPs and 19 hospital consultants. Each of the participants was asked to identify 15 colleagues as appraisers to complete the colleague feedback evaluation tool questionnaire. Factor analysis demonstrates that colleagues have rated all doctors along the four dimensions of effective communication, clinical competence, time-management and trust. After separating GP colleague responses from consultant colleague responses, the application of cluster analysis clearly demonstrates that overall ability as a GP is strongly linked to effective communication with colleagues, whereas for consultants overall ability is based mainly on clinical competence alone. The implications of these findings for the development of future peer evaluation are discussed.

**Rodriguez, HP et al Patient samples for measuring primary care physician performance: who should be included? *Medical Care* 2007 45 (10) 989-996 DOI: 10.1097/MLR.0b013e318074ce63**

**Background::** In measuring patients' experiences with individual primary care physicians (PCPs), the reliability and validity of data based on samples of "established" patients of a physician's panel have been shown. However, as large-scale initiatives seek the least costly approach to obtaining these data, little is known about the implications of expanding samples to include any patient who has seen the physician in the relevant time period. **Methods::** A brief validated patient questionnaire was administered to a random sample of patients visiting 67 PCPs in California between January and October 2005. We evaluated the concordance between administrative and patient-reported information on whether the physician was the patient's PCP. Response rates, data quality, and experiences reported by confirmed "established" patients were compared with those of "unestablished" patients. **Results::** Administrative data designating patients as established to a PCP were highly concordant with patient self-report (96.5%). For unestablished patients, concordance was considerably lower (40.0%). Response rates among established patients were higher than those of patients believed to be unestablished (35.5% vs. 22.2%). Compared with established patients of a PCP's practice, unestablished patients reported significantly less favorable experiences with the doctor (interaction quality,  $P < 0.001$ ; health promotion,  $P < 0.001$ ; access,  $P < 0.001$ ; integration,  $P < 0.05$ ). The ranking of individual physicians differed for established and unestablished patient samples. **Conclusions::** Initiatives measuring patients' experiences with individual primary care physicians will achieve different results (response rates, physician scores) if samples include any patient who has seen the physician versus those whom administrative data indicate as established members of the physician's panel.

**Willcox S et al Measuring and reducing waiting times: a cross-national comparison of strategies *Health Affairs* 2007 26 (4) 1078-87 DOI: 10.1377/hlthaff.26.4.1078**

We compare strategies to manage surgical waiting times in Australia, Canada, England, New Zealand, and Wales to give policy insights into those that are most effective. Most of these countries have allocated dedicated funding and set explicit waiting time targets. Of the five countries, England has achieved the most sustained improvement, linked to major funding boosts, ambitious waiting-time targets, and a rigorous performance management system. While supply-side strategies are used in all five countries, New Zealand and parts of Canada have also invested in demand-side strategies through the use of clinical criteria to prioritize access to surgery

## **RESEARCH AND DEVELOPMENT**

**Davies H, Nutley S, Walter I. Academic advice to practitioners—the role and use of research-based evidence. *Public Money and Management* 2007 27 (4) 232-5 DOI: 10.1111/j.1467-9302.2007.00585.x**

Christopher Pollitt has argued that more systematic attention needs to be given to the advice-giving process whereby academics engage with managers and policy-makers (Pollitt, 2006). An important component of this is the evidence base that underpins academic expertise. We would argue that much of this academic expertise is derived—directly or indirectly—from research, for it is surely through their familiarity with formal research that academic practitioners can lay claim to special categories of knowledge. Moreover, it is not just familiarity with research findings that matter, academics gain great skills and judgement through engagement with the whole research process—from theoretical and conceptual understandings to practical expertise at negotiating research access and managing complex relationships.

**Fenton E, Harvey J, Sturt J. Evaluating primary care research networks. *Health Services Management Research*. 2007 20 (3) 162-73. DOI 10.1258/095148407781395955**

This paper presents a conceptual framework and tool kit, generated from the evaluation of five primary care research networks (PCRN) funded by the then London, National Health Service (NHS) Executive. We employed qualitative methods designed to match the most important characteristics of PCRN, conducting five contextualized case studies covering the five networks. A conceptual evaluation framework based on a review of the organization science literature was developed and comprised the broad, but inter-related organizational dimensions of structure, processes, boundaries and network self-evaluation as input factors and strategic emphasis as epitomized by network objectives. These

dimensions were comprised of more detailed subdimensions designed to capture the potential of the networks to create ideas and knowledge, or intellectual capital, the key construct upon which our evaluation tool kit was based. We considered the congruence, or fit, between network objectives and input factors: greater congruence implied greater ability to achieve implicit and overt objectives. We conclude that network evaluation must take place, over time, recognizing stage of development and potential for long-term viability, but within a generic framework of inputs and outputs. If there is a good fit or congruence between their input factors and network objectives, networks will be internally coherent and able to operate at optimum effectiveness

**Fletcher K et al An analysis of factors that predict patient consent to take part in a randomized controlled trial *Family Practice* August 2007 24 (4) 388 -394 DOI: 10.1093/fampra/cmm019**

Background. Recruitment targets of patients to multi-centre primary care-based randomized controlled trials (RCT) are often not met. A critical step in the pathway is whether an eligible patient will give consent. Objective. To assess whether patient, practice or practitioner characteristics are associated with a patient's likelihood of giving consent to participation in a large primary care-based RCT. Methods. A cross-sectional study of patients from 260 practices in England and Wales who met the eligibility criteria for an RCT of aspirin versus warfarin for stroke prevention and attended an appointment with their GP to consider trial participation. Logistic regression analysis was used to determine which patient and practitioner factors independently predicted whether or not a patient would give consent to take part in the trial. Results. Of the 1740 patients, 973 (55.9%) gave consent. On multivariable analysis, patient factors associated with increased likelihood of giving consent were younger age, current use of warfarin and year of recruitment to the trial. Patients with a history of transient ischaemic attack, angina or valve disease were less likely to give consent. Practice/practitioner factors that were associated with increased likelihood of consent were smaller practice size (practices with greater than eight GPs as compared with those with one to two GPs, odds ratio 0.40, 95% confidence interval 0.21-0.75) and older GPs. Conclusions. The strong association of consent with year of recruitment may be due to changes in trial procedures and investigator training. If so, this has important implications for the conduct of future trials.

**Scott C, Hofmeyer A, Networks and social capital: a relational approach to primary healthcare reform *Health Research Policy and Systems* 25/9/2007 5:9 DOI: 10.1186/1478-4505-5-9**

Collaboration among health care providers and across systems is proposed as a strategy to improve health care delivery the world over. Over the past two decades, health care providers have been encouraged to work in partnership and build interdisciplinary teams. More recently, the notion of networks has entered this discourse but the lack of consensus and understanding about what is meant by adopting a network approach in health services limits its use. Also crucial to this discussion is the work of distinguishing the nature and extent of the impact of social relationships - generally referred to as social capital. In this paper, we review the rationale for collaboration in health care systems; provide an

overview and synthesis of key concepts; dispel some common misconceptions of networks; and apply the theory to an example of primary healthcare network reform in Alberta (Canada). Our central thesis is that a relational approach to systems change, one based on a synthesis of network theory and social capital can provide the foundation for a multi-focal approach to primary healthcare reform. Action strategies are recommended to move from an awareness of 'networks' to fully translating knowledge from existing theory to guide planning and practice innovations. Decision-makers are encouraged to consider a multi-focal approach that effectively incorporates a network and social capital approach in planning and evaluating primary healthcare reform.

**Maynard A. Translating evidence into practice: why is it so difficult? *Public Money and Management* 2007 27 (4) 251-6. DOI: 10.1111/j.1467-9302.2007.00591.x**

Health and social care research in the UK into policy and practice often leads the world in terms of methodological development and empirical application. However, translating evidence into practice requires radical changes in the behaviour of the producers of evidence (for example academics) and even more importantly in the users of evidence. Policy-makers and practitioners lack the skills and incentives to access and apply evidence. This reflects their poor training and incentives that induce a focus on tactics rather than strategy. Academics need to use robust quantitative methods and acquire insulation from the siren calls of commercially-induced bias.

## **RESEARCH METHODS**

**May CR, et al Process evaluation for complex interventions in primary care: understanding trials using the normalization process model. *BMC Family Practice* 2007 8:42. DOI: 10.1186/1471-2296-8-42**

Background: The Normalization Process Model is a conceptual tool intended to assist in understanding the factors that affect implementation processes in clinical trials and other evaluations of complex interventions. It focuses on the ways that the implementation of complex interventions is shaped by problems of workability and integration. Method: In this paper the model is applied to two different complex trials: (i) the delivery of problem solving therapies for psychosocial distress, and (ii) the delivery of nurse-led clinics for heart failure treatment in primary care. Results: Application of the model shows how process evaluations need to focus on more than the immediate contexts in which trial outcomes are generated. Problems relating to intervention workability and integration also need to be understood. The model may be used effectively to explain the implementation process in trials of complex interventions. Conclusion: The model invites evaluators to attend equally to considering how a complex intervention interacts with existing patterns of service organization, professional practice, and professional-patient

interaction. The justification for this may be found in the abundance of reports of clinical effectiveness for interventions that have little hope of being implemented in real healthcare settings

**Warren V. Health technology appraisal of interventional procedures: comparison of rapid and slow methods. *Journal of Health Services Research and Policy* 2007 12 (3) 142-6 DOI: 10.1258/135581907781542996**

Objective: To describe a method for the rapid appraisal of new interventional procedures and to compare its conclusions with those derived from a slower, more thorough method. Methods: Explanation of an algorithm, pragmatically developed over a decade at the British United Provident Association (BUPA), to classify requests for funding for new interventional procedures as 'Fund routinely'; 'Fund as a one-off'; 'Fund in trial only'; 'Do not fund currently' within about 48 hours. Comparison of the resulting categorizations of 39 interventional procedures against the subsequent work of the English National Institute for Health and Clinical Excellence (NICE) Interventional Procedures team. The first two BUPA categories were equated with NICE's 'evidence adequate' and the second two with 'evidence inadequate'. Results: The algorithm is fit for purpose. It facilitated 114 requests for funding, received before June 2005, being successfully allocated: fund routinely, 33 (28.9%); fund as a one-off, 20 (17.5%); fund in trial only, 37 (32.5%); do not fund, 24 (21.1%). NICE subsequently categorized 18 being 'evidence adequate' and 21 'evidence inadequate'. There was concordance between BUPA and NICE on 35/39 (90%) of the topics. The four discrepancies are discussed. Conclusion: Rapid appraisal of new interventional procedures using the BUPA algorithm is feasible and in most instances its output is similar to that obtained from a slower more thorough method

**Williamson M K, et al. Recruiting and retaining GPs and patients in intervention studies: the DEPS-GP project as a case study. *BMC Medical Research Methodology* 2007 18/9/2007 7:42 DOI: 10.1186/1471-2288-7-42**

Background Recruiting and retaining GPs for research can prove difficult, and may result in sub-optimal patient participation where GPs are required to recruit patients. Low participation rates may affect the validity of research. This paper describes a multi-faceted approach to maximise participation of GPs and their patients in intervention studies, using an Australian randomised controlled trial of a depression/suicidality management intervention as a case study. The paper aims to outline experiences that may be of interest to others considering engaging GPs and/or their patients in primary care studies. Methods A case study approach is used to describe strategies for: (a) recruiting GPs; (b) encouraging GPs to recruit patients to complete a postal questionnaire; and (c) encouraging GPs to recruit patients as part of a practice audit. Participant retention strategies are discussed in light of reasons for withdrawal. Results The strategies described, led to the recruitment of a higher than expected number of GPs (n=772). Three hundred and eighty three GPs (49.6%) followed through with the intent to participate by sending out a total of 77,820 postal questionnaires, 22,251 (28.6%) of which were returned. Three hundred and three GPs (37.0%) participated in the practice audit, which

aimed to recruit 20 patients per participating GP (i.e., a total of 6,060 older adults). In total, 5,143 patients (84.9%) were represented in the audit. Conclusions Inexpensive methods were chosen to identify and recruit GPs; these relied on an existing database, minor promotion and a letter of invitation. Anecdotally, participating GPs agreed to be involved because they had an interest in the topic, believed the study would not impinge too greatly on their time, and appreciated the professional recognition afforded by the Continuing Professional Development (CPD) points associated with study participation. The study team established a strong rapport with GPs and their reception staff, offered clear instructions, and were as flexible and helpful as possible to retain GP participants. Nonetheless, we experienced attrition due to GPs' competing demands, eligibility, personnel issues and the perceived impact of the study on patients. A summary of effective and ineffective methods for recruitment and retention is provided.

## WORKFORCE

**Abbott S, Leadership across boundaries: a qualitative study of the nurse consultant role in English primary care. *Journal of Nursing Management* 2007 15 (7) 703-710 DOI: 10.1111/j.1365-2934.2006.00736.x**

**Aim** To explore the emerging role of nurse consultant in an English primary care setting. **Background** Nurse consultants have been introduced in England since 1999 as senior, non-managerial nurse leaders. They have generally found it that it takes time to negotiate manageable work-loads. **Design** Four qualitative case studies **Methods** Semi-structured interviews with stakeholders within the organization. Data were analysed thematically. **Findings** All four nurse consultants might potentially work with a very large number of disciplines, departments and other organizations. As a result, it took time to identify priorities and to make relationships. Thus, although nurse consultants are well-placed to work across boundaries, two had made relatively little progress in doing so. **Conclusion** Nurse consultants working in primary and community health care settings are well-placed to be boundary-spanners, delivering change across organizations. Negotiating priorities and relationships are time-consuming tasks, and nurse consultants may have to work with a restricted number of partners initially.

**Ericson-Lidman E, Strandberg G Burnout: co-workers' perception of signs preceding workmates' burnout *Journal of Advanced Nursing* 60 (2) 199-208 DOI: 10.1111/j.1365-2648.2007.04399.x**

**Aim.** This paper is a report of a study to describe co-workers' perceptions of signs preceding workmates' burnout. **Background.** Burnout engenders emotional and economic suffering, both individual and societal. It is therefore important to learn to recognize early

signs to prevent burnout and co-workers, who have opportunities to recognize such signs, are valuable resources in this context. Method. Fifteen interviews were conducted with nursing and medical staff in Sweden who had worked with a person who developed burnout. The interviews took place in 2004 and were analysed using a thematic content analysis. The narratives were obtained when co-workers already knew that their workmates were on sick leave because of burnout or had left their employment after sick leave because of burnout. Findings. The findings show that co-workers retrospectively recalled a multiplicity of signs. They perceived that the people concerned were struggling to manage alone, showing self-sacrifice, struggling to achieve unattainable goals, becoming distanced and isolated, and showing signs of falling apart. Conclusions. Some of the signs preceding workmates' burnout may be difficult to interpret as signs of burnout, because they may be regarded as qualities which are to some extent encouraged in the prevailing culture. The findings provide a complex picture of these signs that will hopefully increase our awareness of and ability to recognize such signs to facilitate the possibilities of our helping in time. The sub-themes and themes in the present study may also serve as a basis for supervisors involved in supporting clinical staff.

**Esmail, A Asian doctors in the NHS: service and betrayal *British Journal of General Practice* 2007 57 (543) 827-831**

Current estimates suggest that almost one-third of doctors practising in the NHS are from overseas and that the vast majority of these overseas doctors are from the Indian subcontinent. This of course is a surprising statistic because within the general population ethnic minorities represent only about 8% of the population of the UK. Why are so many doctors from the Indian subcontinent practising in the UK? Why do they come here and what has been their experience of working in the NHS? Although they are such a significant and visible part of the NHS, it is surprising how little we know about this group. The purpose of this paper is to make an attempt at understanding the contribution of Asian doctors to the development of the NHS, and more generally, to British medicine.

**Glasberg AL, Norberg A, Soderberg A Sources of burnout among healthcare employees as perceived by managers *Journal of Advanced Nursing* 60 (1) 10-19 DOI: 10.1111/j.1365-2648.2007.04370.x**

Aim. This paper is a report of a study to investigate healthcare managers' perspectives on factors contributing to the increase of healthcare employees on sick leave for burnout symptoms. Background. Current turbulent healthcare reorganization has resulted in structural instability, role conflicts and vague responsibility commitments, all of which contribute to increasing numbers of sick days caused by burnout symptoms. Managers' perceptions of burnout sources are important as these perceptions guide the actions taken to prevent burnout. Method. Interviews were carried out with 30 healthcare managers, with different occupational backgrounds and from different units. The data were collected in Sweden in 2003 and analysed using thematic qualitative content analysis. Findings. According to the healthcare managers, continuous reorganization and downsizing of

healthcare services has reduced resources and increased demands and responsibilities. These problems are compounded by high ideals and expectations, making staff question their own abilities and worth as well as making them feel less confirmed and less valued as people. The main finding indicates that healthcare employees are thrown into a spiralling sense of inadequacy and an emerging sense of pessimism and powerlessness. Conclusion. To understand and influence people's actions, one has to understand their perceptions and thoughts – their explanatory models. This study shows the complexity and interconnection between sources of burnout as perceived by healthcare managers, and highlights the encouragement of realism without the destruction of enthusiasm as an important factor in management and healthcare practice.

**Hart LG, Skillman SM, Fordyce M, Thompson M, Hagopian A, Konrad TR. International medical graduate physicians in the United States: changes since 1981. *Health Affairs* 2007; 26 (4) 1159-69.**

Abstract: Nearly a quarter of all active U.S. physicians are international medical graduates (IMGs)--physicians trained outside the United States and Canada. We describe changes in characteristics of IMGs from 1981 to 2001 and compare them with their U.S. medical graduate (USMG) counterparts. Since 1981, the leading source countries for IMGs have included India, the Philippines, and Mexico. IMGs were more likely to be generalists and to practice in designated underserved areas than USMGs but slightly less likely to practice in isolated small rural areas and persistent-poverty counties. IMGs are an important source of primary care physicians in rural and underserved areas

**Kangasniemi M, Winters LA, Commander S. Is the medical brain drain beneficial? Evidence from overseas doctors in the UK. *Social Science and Medicine* 2007 65 (6) 915-23. DOI: 10.1016/j.socscimed.2007.04.021**

The 'beneficial brain drain' hypothesis suggests that skilled migration can be good for a sending country because the incentives it creates for obtaining training increase that country's net supply of skilled labour. Necessary conditions for this hypothesis to work are that the possibility of migration significantly affects decisions to take medical training and that migrants are not strongly screened by the host country. We conducted a survey among overseas doctors in the UK in 2002, which suggested that neither condition is likely to be fulfilled. Apart from the 'beneficial brain drain' argument, the survey findings also cast light on the backgrounds and motives of migrant doctors, and finds evidence that there could, nonetheless, be other benefits to sending countries via routes like remittances and return migration.

**Kanste O; Kyngas H; Nikkila J The relationship between multidimensional leadership and burnout among nursing staff *Journal of Nursing Management* 2007 15 (7) 731-739 DOI: 10.1111/j.1365-2934.2006.00741.x**

**Aim and background** The purpose was to explore the relationship between multidimensional leadership and burnout among nursing staff. There exists little research evidence of the relation between these phenomena. **Method** The study used a non-experimental survey design. The sample consisted of 601 nurses and nurse managers working in different health care organizations. **Results** Rewarding transformational leadership seems to protect particularly from depersonalization. Active management-by-exception protected from depersonalization and increased personal accomplishment. Passive laissez-faire leadership functioned as an exposing factor for emotional exhaustion as well as a decreasing factor for personal accomplishment. However, the employment status and the character of work tasks affected the connection between leadership and burnout. **Conclusions** The relation between leadership and burnout is complex, affected by situational factors of leadership and the ambiguous nature of burnout. Nurses of various ages, at different stages of career development and participating in different work tasks require different kinds of leadership.

**May J et al, GP perceptions of workforce shortage in a rural setting *Rural and Remote Health* 15<sup>th</sup>/8/2007 Epub 7 (3) 720**

**Introduction:** Currently Australia is experiencing a rural medical workforce shortage, especially among GPs. Strategies aimed at improving this shortage have generally been directed at small and remote rural communities (RRMA 4-7); however, longstanding GP shortages also continue in large (RRMA 3) rural communities. The key to the understanding the rural workforce is the perceptions of GPs themselves. This article compared GP perceptions of workforce shortages in Tamworth, New South Wales, Australia (an RRMA 3 town) with actual levels of workforce participation. **Methods:** A survey of 31/33 GPs working in the New South Wales town of Tamworth was conducted in 2005. Participating GPs were individually interviewed and were asked to estimate local GP workforce needs, calculate their weekly consulting time sessions and advise if they were accepting new patients. The survey was repeated 12 months later with the same cohort to track workforce change. **Results:** In May 2005 there were 27.8 full time equivalent (FTE) GPs working in Tamworth (population 42 000). In May 2006 this had risen to 31.5 FTE practitioners. Initially, all practitioners surveyed believed there was a workforce shortage, with no practice accepting new patients. This shortage was perceived to be >10 FTE GPs (6.5%), between 5-9 GPs (64.5%) and between 1-4 GPs by 29% of surveyed GPs. In June 2006 there were 31.5 FTE GPs working in Tamworth. The follow-up survey of 29 GPs revealed a significant shift in their perceptions with only 41.4% of GPs perceiving the shortage as 1-4 FTE GPs ( $p = 0.2$ ), 17.2% between 5-9 GPs and 41.4% nil. No GPs in the follow-up survey perceived the shortage as >10. At the end of the 12 month study period, 8 of 17 practices were accepting new patients. **Conclusion:** GP perceptions of shortage largely reflected concurrent workforce changes that occurred during the study period where there was a 12% improvement after a prolonged period of workforce stagnation. This change drove improvements in patient access and in many GPs' minds ameliorated much of the perceived shortage. Many factors may be involved, including the increased use of practice nurses, private billing and start-up capacity. General practitioner perceptions appear to be sensitive to workforce changes, with sampled GPs working with higher patient ratios than those seen as acceptable in metropolitan areas.

**Mills J, Francis K, Bonner A** The problem of workforce for the social world of Australian rural nurses: a collective action frame analysis *Journal of Nursing Management* 2007 15 (7) 721-730 DOI: 10.1111/j.1365-2934.2006.00738.x

**Aim and background** Globally, nursing workforce shortages are a hot topic for discussion among politicians, academics and clinicians. This paper uses collective action framing to analyse the literature about the problem of workforce for Australian rural nurses. **Evaluation** As part of a larger constructivist grounded theory study, we utilize collective action framing to bridge social world mapping and the literature. Data sources included journal databases, newspapers, newsletters and websites. We limited the years searched from 2000 to 2005. This analytical heuristic categorizes text into three main categories: diagnoses of a problem, postulations of solutions and actions to motivate change. **Key issues** Having mapped the social world of Australian rural nurses as comprising four groups of collective actors - community, advocates, academics and government - we trace the texts that they have produced with a focus on mentoring as a potential solution to the problem of workforce. **Conclusions** Mentoring entered the literature about the problem of workforce for Australian rural nurses because of a combination of political and academic will. These collective groups are now changing how they are framing the problem of workforce to focus instead on the globalization of nursing workforce shortages, which is resulting in diminished support for mentoring activities in clinical practice.

**Sandhu B, Magerison C, Holdcroft A,** Women in the UK academic medicine workforce *Medical Education* 2007 41 (9) 909-14 DOI: 10.1111/j.1365-2923.2007.02825.x

**Objectives:** This study aimed to compare data on the employment profiles (such as grade, place of work, etc.) of male and female clinical academics. **Methods:** We carried out a comparative review of workforce data within academic medicine for 2004 and 2005, pertaining to the workforce in all specialties in UK medical schools. **Results:** We identified 3255 and 3365 lecturers, senior lecturers, readers and professors in 2004 and 2005, respectively, of whom 21% were women. In 2004 and 2005, 12% and 11%, respectively, of 1157 and 1364 UK medical professors were women. The number of women filling such positions in individual schools ranged from 0% to 33% across schools. The total numbers of women post-holders and their full-time equivalents were similar, indicating that the majority of posts were full-time. **Conclusions:** In England only 1 in 10 medical clinical professors are women. At the onset of the study period, 6 medical schools employed no female professors, with a consequent lack of female role models at these institutions. Large variations between schools suggest that some workforce practices may be detrimental to women's academic careers.



